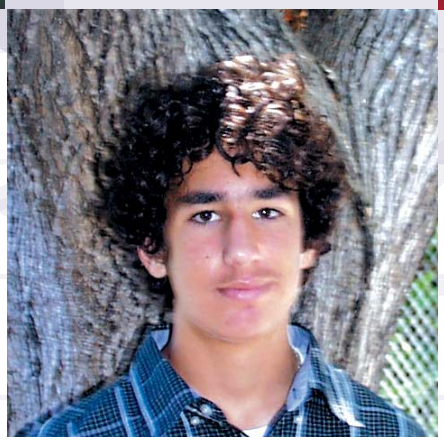
Santa Clara County's Children and Youth

Key Indicators of Well-Being



2003

Santa Clara County's Children and Youth

Key Indicators of Well-Being
2003

Public Health Department
Santa Clara Valley Health & Hospital System

CROSS•SYSTEMS
EVALUATION

Dear colleagues and community members,

The Santa Clara County Public Health Department, in collaboration with Santa Clara County Cross Systems Evaluation, is pleased to present Santa Clara County's Children and Youth: Key Indicators of Well-Being, 2003 report. A total of 478,643 children under age 18 live in Santa Clara County. This comprehensive report provides extensive data on the status of our children's well-being and highlights significant disparities across health, education, criminal justice and social welfare indicators by age, gender, ethnicity, and race.

The mission of the Public Health Department is to serve all people of Santa Clara County by protecting health; preventing disease, injury, premature death and disability; promoting healthy lifestyles, behaviors and environments; and responding to disasters, disease outbreaks and epidemics. To fulfill this mission, the Public Health Department must continuously monitor the health status of the community and communicate findings to the public at-large. Cross Systems Evaluation is an interagency county initiative that seeks to evaluate the effectiveness of County services for children and youth. An important component of evaluation is ensuring that services address priority issues and populations. The Santa Clara County's Children and Youth: Key Indicators of Well-Being, 2003 report is one way the Public Health Department and Cross Systems Evaluation fulfill their respective missions.

This report is a planning tool for organizations and community groups. It is our hope that the information will serve to heighten awareness about important children's issues and assist in focusing action to address those issues.

Sincerely,

Guadalupe S. Olivas, PhD
Director, Public Health Department

Sandra Nathan, PhD
Deputy County Executive

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Design and Layout by Dion Desktop Publications

Contents

Suggested citation:

Santa Clara County (CA, US). Santa Clara County's Children and Youth, Key Indicators of Well-Being, 2003. San Jose, CA: Santa Clara County Public Health Department and Cross Systems Evaluation; 2003 June. Available online at www.sccphd.org/statistics2/

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Introduction

Background

Santa Clara County's Children and Youth: Key Indicators of Well-Being, 2003 report is the first report collaboratively developed by the Santa Clara County Public Health Department and Cross Systems Evaluation. Both county departments have the goal of providing the community with access to information regarding the well-being of residents in Santa Clara County, including children and youth.

In 1999, the Public Health Department published the Children and Youth: Key Indicators of Well-Being Report using results from the Youth Behavioral Risk Factor Survey adapted by the Center for Disease Control and Prevention (CDC). Unlike the 1999 report, this report uses primary data gathered from the California Healthy Kids Survey (CHKS) results administered to 7th, 9th, and 11th graders at public schools in Fall 2001 and Spring 2002, and developed by the California Department of Education. A customized Public Health module accompanied the CHKS that included questions from the previously conducted Youth Behavioral Risk Factor Survey in 1999.

By presenting the overall welfare of youth and identifying disparities, the purpose of this report is to serve as a tool or action guide for local agencies, communities, planners, and policy makers to develop plans for improving health and enhancing the quality of life among children and youth in Santa Clara County.

Overview of Report

Data presented in this report represent three types of sources. The primary source of data is taken from CHKS results gathered from public schools throughout Santa Clara County. Primary Public Health Department data and secondary countywide data from other county Cross Systems Evaluation partners, relevant surveys, state reports, and local studies are also incorporated in this report. Data collection processes are described in the Methodology section.

The County Profile section provides readers with background information about Santa Clara County to help put a perspective on the county's population and other various factors that affect local youth. Categories of indicators described here are demographics, economics, housing, and transportation.

Following the introductory County Profile are four domains that encompass indicators influencing the lives of youth and children, based on Cross Systems Evaluation's comprehensive framework. These domains are **Health & Well-Being, Family Stability, School Success,** and **Community Safety**. The Health & Well-Being domain describes the health status of the County's children and youth with respect to access to health care, early childhood, morbidity and mortality, communicable diseases, behavioral health, and emotional health. Family Stability addresses how family composition and violence/abuse may affect youth and their development. School Success provides information on the educational profile of schools, school performance, classroom and teacher profile, and school environment support. The Community Safety domain depicts how local youth perceive the safety of their neighborhoods and the potential dangers in their neighborhoods, as well as juvenile offenses committed.

This report presents an overview of children's and youth's health and development status according to indicators in these domains and compares the county-level data to the Centers for Disease Control's (CDC) Healthy People 2010 Objectives and the rest of California or the nation's youth. Hence, the overall format of each indicator includes background information, a comparison box depicting how Santa Clara County is doing with respect to the Healthy People 2010 Objectives, California or the nation, and key data findings.

The Closing Documents contain a Conclusions section highlighting disparities and other significant issues affecting the health and development of Santa Clara County's children and youth, along with recommended actions for intervention and support. Input solicited during a community forum hosted by Cross Systems Evaluation and the Public Health Department is incorporated into this report as well. The Glossary explains and defines terms and acronyms for readers. Finally, a CHKS Comparisons Report Matrix compares the results of questions asked in the Santa Clara County CHKS 2002 with the Youth Risk Behavior Survey administered in 1997, the statewide CHKS, and the National Youth Risk Behavior Survey 2001.

Methodology

Background

The California Healthy Kids Survey (CHKS) was conducted among middle and high school students in the county during the 2001-2002 school year. The survey replaced the Public Health Department's administration of the Youth Risk Behavior Survey (YRBS). In 1997, the Santa Clara County Public Health Department administered the YRBS, which was developed by the Centers for Disease Control and Prevention (CDC), to a countywide representative sample of schools. The YRBS is used to monitor the priority health risk behaviors that contribute to the leading causes of morbidity, mortality, and social problems among youth and young adults in the United States. In 2000, the Public Health Department approached a second administration of the YRBS at the same time schools were getting ready to administer a California Department of Education mandated survey, the CHKS. Thus, a collaborative approach was undertaken with the Public Health Department, CHKS, the Santa Clara County Office of Education (COE), and school districts to streamline and administer one joint survey. A new public health custom module (Module G) was created and added to the CHKS. Specific questions on priority health risk behaviors were taken from other modules in the CHKS series. The public health module was administered along with the CHKS core module (Module A). In addition, many students completed Module B, the tobacco module that is required for high schools receiving state Tobacco Use Prevention and Education funding.

Sampling

CHKS was administered to middle and high school students throughout county school districts. The sampling frame consisted of 7th graders in middle schools and 9th and 11th graders in high schools.

The sampling methodology was determined at the district-level. All schools in the district participated in the survey unless there were more than 10 schools in which case 10 schools were randomly selected to participate. At each school of 900 students or less, all students were asked to participate. If there were more than 900 students, classrooms were randomly selected to enroll 900 students. Number of classrooms was determined based on the enrollment size of the school. Districts were given the option to enroll more students or more schools if they wanted to do so. Consent from parents was obtained before administering the survey.

A total of 16,911 students participated in the survey. Of these, 927 students did not check their grade level and were excluded from final analysis. Therefore, the final sample included 15,984 students: 47.9% males and 52.1% females. The proportion of students in 7th, 9th, and 11th grades were 42.8%, 29.9%, and 27.3% respectively. The student sample included: 29.6% White, 26.4% Hispanic, 3.2% African-American, 31.2% Asian or Pacific Islander, 0.9% Native American or Alaskan Natives, and 8.2% unknown.

Data Analysis

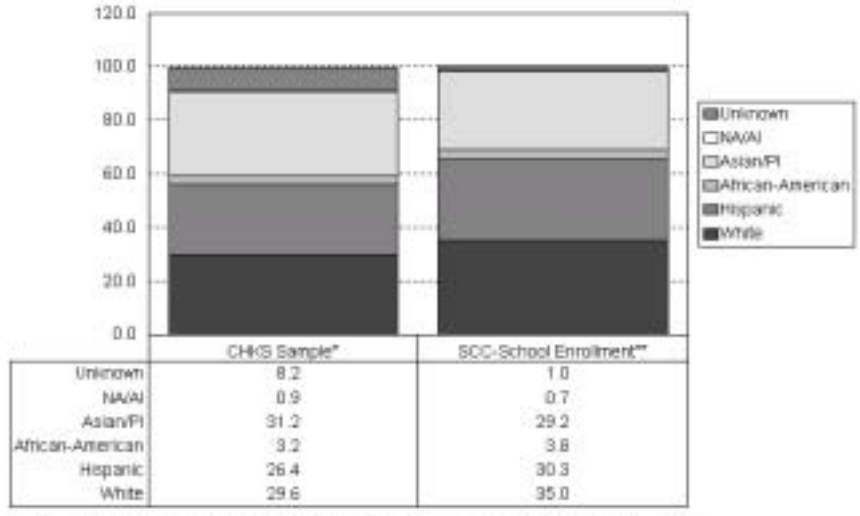
Data analysis was performed by using SPSS for Windows (Version 11.1). Data were carefully reviewed and cleaned by visual and logical checks. For calculating the 95% confidence interval (CI) of proportion, the software PHRate was used.

Weighting

The final analysis presented data on weighted variables. Because the demographics of the student population in the CHKS differed from the demographics (race/ethnicity, grade, and gender) of the student population of Santa Clara County, weights were created to make the student population in the final analysis more representative of the Santa Clara County student population. Weights were adjusted so as not to inflate the sample size artificially.

Comparison of 2002 CHKS and SCC Student Population by Race/Ethnicity

California Healthy Kids Survey - Santa Clara County, 2002



	CHKS Sample*	SCC-School Enrollment**
Unknown	8.2	1.0
NA/AI	0.9	0.7
Asian/PI	31.2	29.2
African-American	3.2	3.8
Hispanic	26.4	30.3
White	29.6	35.0

* Unweighted CHKS sample, ** Enrollment in grade 7, 9, and 11 during 2001-2002 school year in Santa Clara County
Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002; California Department of Education.

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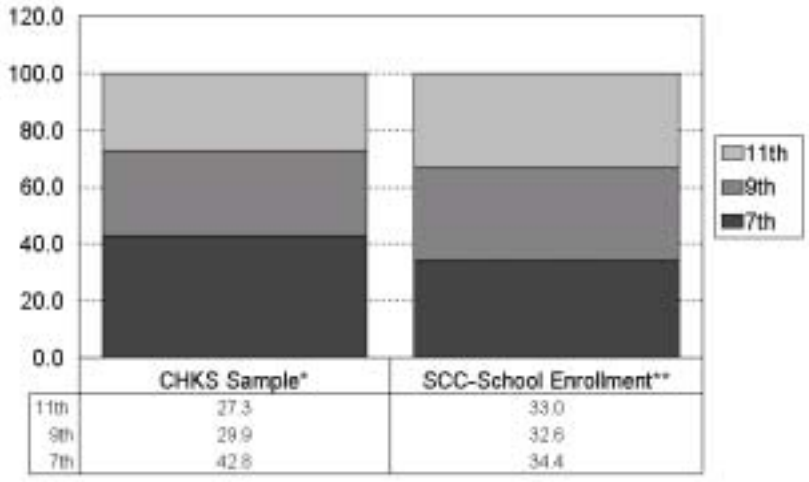
Methodology continued

Comparison of 2002 CHKS and SCC Student Population by Grade

California Healthy Kids Survey - Santa Clara County, 2002

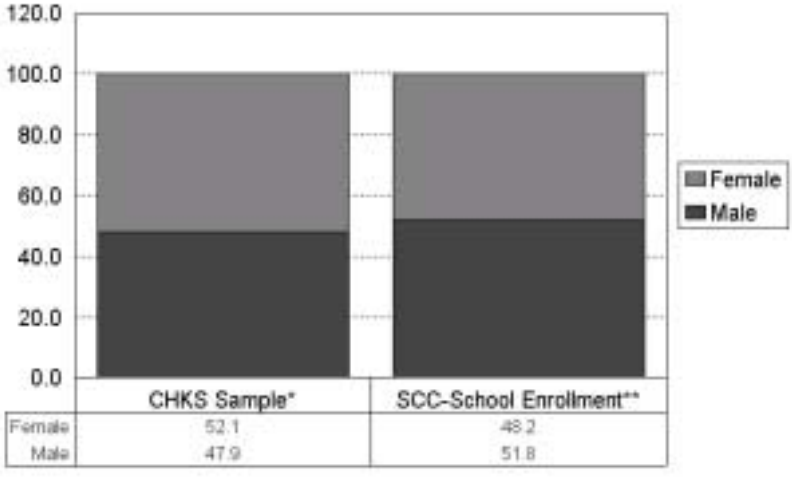


	CHKS Sample*	SCC-School Enrollment**
11th	27.3	33.0
9th	29.9	32.6
7th	42.8	34.4

*Unweighted CHKS sample, **Enrollment in grade 7, 9, and 11 during 2001-2002 school year in Santa Clara County
Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002; California Department of Education.

Comparison of 2002 CHKS and SCC Student Population by Gender

California Healthy Kids Survey - Santa Clara County, 2002



	CHKS Sample*	SCC-School Enrollment**
Female	52.1	48.2
Male	47.9	51.8

*Unweighted CHKS sample, **Enrollment in grade 7, 9, and 11 during 2001-2002 school year in Santa Clara County
Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002; California Department of Education.

Statistical analysis

Both univariate and bivariate analysis were performed to compare outcome variables. The proportions of participants with each outcome variable were compared using Chi-Square test. For comparing categorical variables in more than two categories, a chi-square for trend was computed to examine a linear relation with grade levels. Unadjusted odds ratios (ORs) and 95% confidence intervals (95% CIs) were calculated to examine the association of each socioeconomic, demographic, and other undesirable behaviors with academic achievements (grade point average). Finally, a logistic regression model was run to adjust the effect of confounding variables such as socio-demographic variables (age, sex, education, income, marital status etc.) and other risk behaviors on academic performances (such as Odds of poor academic performance for using a drug) and the adjusted ORs (95% CIs) were presented. Statistical significance was accepted at a probability level of 0.05 (two-sided exact significance). For Chi-Square test, Fisher's exact test F values were used if a cell frequency was < 5.

Limitations

The CHKS is biased in several ways and therefore may need to be interpreted with caution. First, students could be excluded from participation at different stages during the study. This uncontrollable and selective refusal rate may have resulted in skewed samples. Therefore, a recommendation to focus on the analysis of countywide data rather than focusing on individual district or school level data, is put forth because a larger sample size is more resistant to extreme values. Second, the survey was conducted in public schools and is not representative of private schools. Finally, as this was a self administered survey there were inconsistencies in answering different questions which could not be validated at the time of data collection.

Primary (Public Health) Data Collection

Various Public Health Databases served to provide primary data to complement, or in some cases, highlight an indicator within the Health & Well-Being domain of this report. The sources include: Birth Records; Death Records; Confidential Morbidity Reports (CMR); Patient Discharge Database (PDD); Tuberculosis Information & Management System (TIMS); HIV & AIDS Reporting System (HARS); Perinatal Hepatitis B Surveillance Program; Surveillance, Epidemiology, and End Results (1992-1999); and Behavioral Risk Factor Survey 2000.

Some of the criteria that were applied in considering inclusion of these data were:

1. Data must be representative of the county population.

2. Data must encompass population under 18 years of age.

Where available, data were obtained by age groups, gender, ethnicity, and for multiple years (trend data).

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Methodology continued

Some exceptions were made where data was not truly representative of the county but highlighted the importance of the indicator, showed disparities, and addressed a data gap. These sources included Child Health and Disabilities Program (CHDP), Women, Infants, and Children (WIC), and Breast Feeding Survey.

Secondary Data Collection

Secondary data were collected from a variety of sources, including county agency databases, county agency reports, state and national reports and web sites, and policy and service organization reports and web sites. Three criteria were applied in considering the inclusion of secondary data. First, data must be representative of the county population. Second, the data must be no older than 1999 with preference for the most current data. Third, data must encompass population under 18 years of age. If available, secondary data were obtained by age groups, gender, ethnicity, and for multiple years (trend data). To the extent possible, secondary data were validated by content experts on the report planning committee.

For more specifics about CHKS analysis or sample methodology, please contact Epidemiology and Data Management, Public Health Department, Division of Research, Planning and Evaluation (408) 423-0736.

County Profile

Demographics

Santa Clara County's population is comprised of people from diverse cultures, nationalities, and racial groups. Over the last few decades, profound changes have occurred in the number of people living in the county, the diversity of the population, and household characteristics. Demographic indicators include population changes and shifts, gender and age group distribution, ethnic composition in the county and among students, foreign-born residents, and primary languages of students.

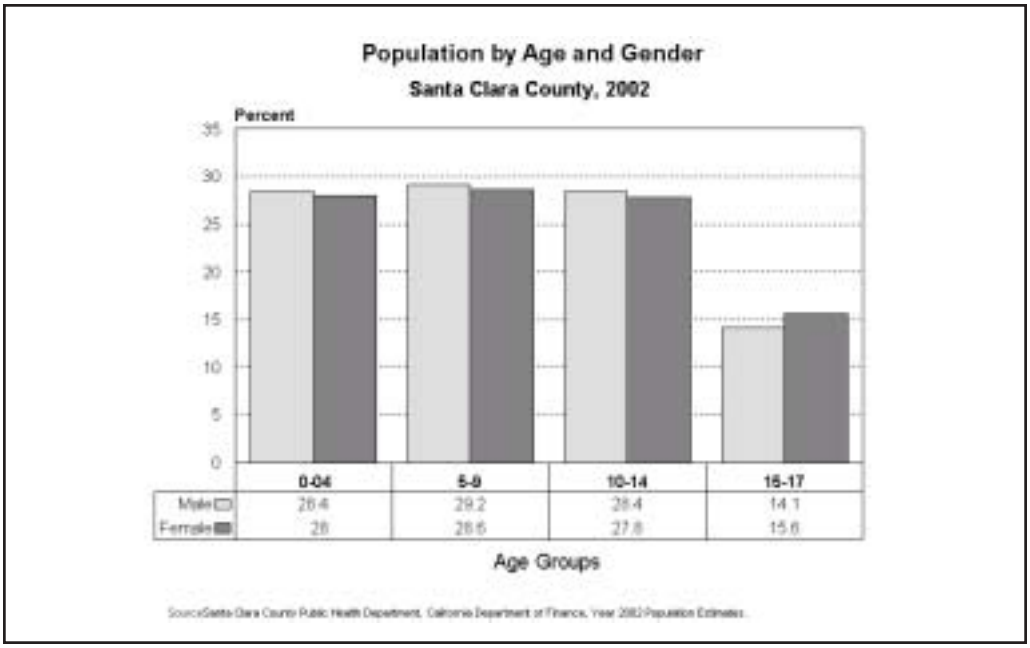
Population

Santa Clara County was home to 1,668,309 residents in 2001, nearly 5% of the state's population. Although most changes and shifts in demographics have been accompanied by increases in the population size, the percent population change from 2000 to 2001 showed a slight decrease of 0.8%.[1] Youth age 17 and under comprised 34% of the total county population in 2002, for a total of 478,643.[2]

Gender, Age and Ethnic Distribution: Youth 0-17 Years

Of those under 18 years of age, 51% were male and 49% were female (Figure 1). About 28% of the children in Santa Clara County were between age 0-4; 29% were between age 5-9; 28% were between age 10-14. According to the California Department of Finance population estimates for 2002, 35.3% of the county's population under 18 years of age was White, 31.2% was Hispanic, 29.8% was Asian/PI, 3.6% was African American, and 0.2% was categorized as Other (includes Native Americans) (Figure 2).

Figure 1



Gender, Age and Ethnic Distribution: Youth 0-17 Years

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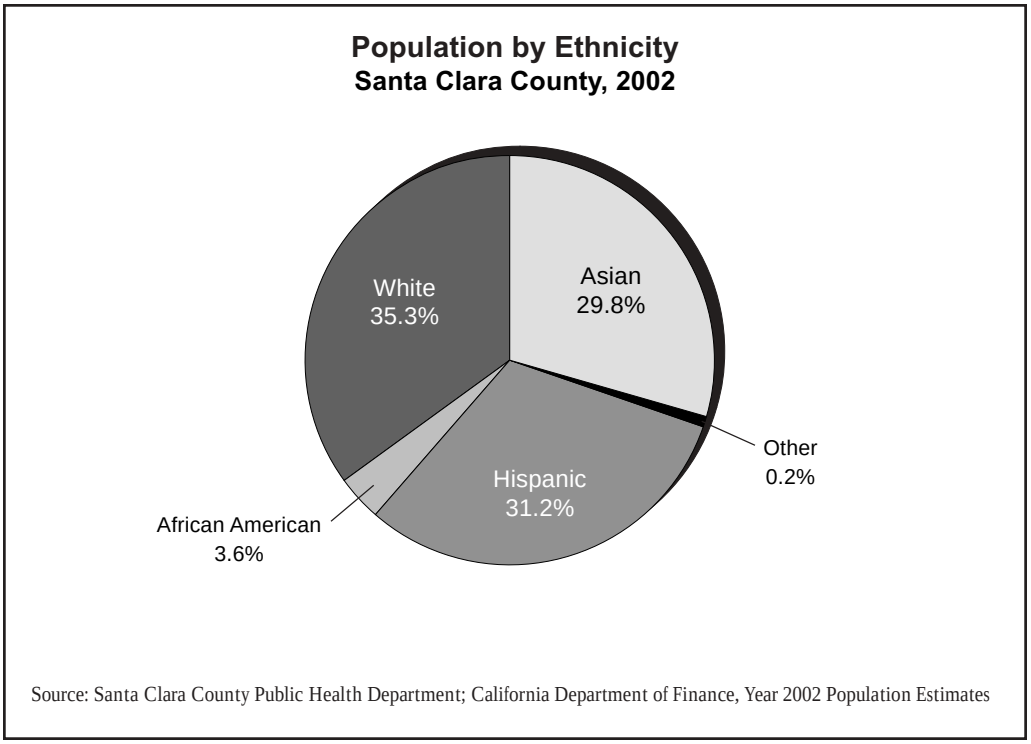
Figure 2



Source: Santa Clara County Public Health Department; California Department of Finance, Year 2002 Population Estimates

Foreign-Born Residents

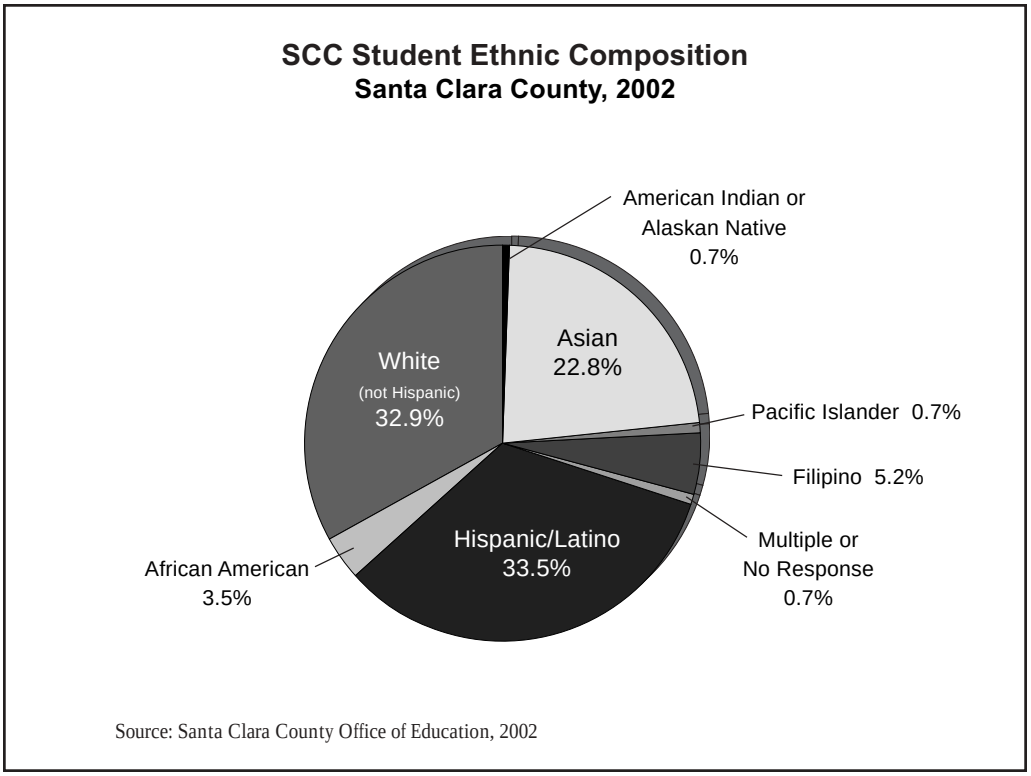
In Santa Clara County during 2000, 34.1% of the overall population was foreign-born. San Jose ranked third among large metropolitan areas, behind Miami and Los Angeles, in the proportion of foreign-born residents.[3] Among the foreign-born residents, 45.4% of those age five and older spoke a language other than English at home. Nearly half (48.4%) of those who were foreign born described themselves as speaking English, "less than very well."[1]

Ethnic Composition and Language of Students

The San Jose metropolitan area ranks third in the country behind Los Angeles and New York in terms of ethnic diversity.[3] Among Santa Clara County students in 2000, the largest ethnic/racial groups were Hispanic/Latino and White, followed by Asian (Figure 3).

The county's ethnic and racial diversity is evident among the youth in local schools. According to the Santa Clara County Office of Education, the ten languages most spoken among students in the county's public schools in 2001 (in alphabetical order) were Cantonese, English, Farsi (Persian), Korean, Mandarin (Putonghua), Other, Pilipino (Tagalog), Russian, Spanish, and Vietnamese. Other languages spoken by students include Albanian, Arabic, Armenian, Assyrian, Burmese, Cebuano (Visayan), Chamorro (Guamanian), Chaozhou (Chaochow), Croatian, Dutch, French, German, Greek, Gujarati, Hebrew, Hindi, Hmong, Hungarian, Ilokano, Indonesian, Italian, Japanese, Khmer (Cambodian), Khmu, Kurdish, Lao, Mien, Pashto, Polish, Portuguese, Punjabi, Rumanian, Samoan, Serbo-Croatian, Taiwanese, Thai, Tigrinya, Toishanese, Tongan, Turkish, Ukrainian, and Urdu.[4]

Figure 3



Economics

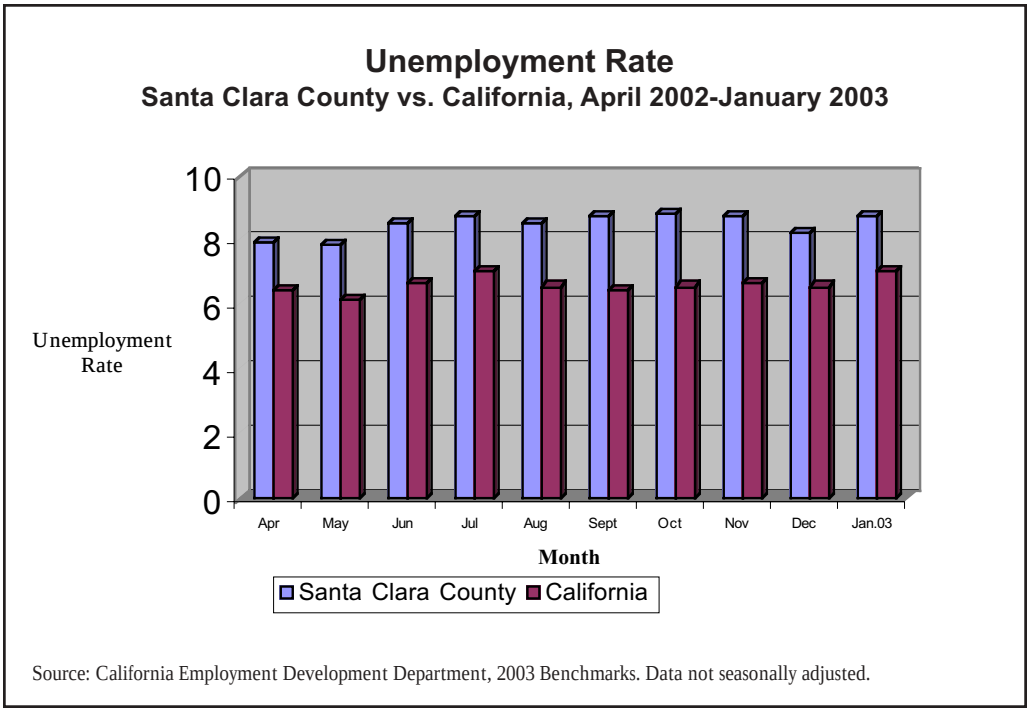
Santa Clara County is one of the largest and most prosperous counties in California and the nation. Yet, recent decline in the high-technology industry has contributed to decline in the county's economy. Indicators included in this section are unemployment and job growth, poverty, household income, public assistance (i.e. Cal-Works and Welfare), and free/reduced meals in schools. These indicators measure the economic status of the community in which the county's children are raised and directly impact the quality of life of children and their families. Because 'real-time' data on economic indicators are not immediately available, the data presented in this section should be interpreted in light of changing economic factors in Santa Clara County.

Unemployment & Job Growth

The unemployment rate represents the number of individuals who are unemployed as a percent of the labor force. It is determined by a monthly survey conducted by the Bureau of Labor Statistics.[5] The job market is shifting throughout the nation, and employment circumstances in Santa Clara County are no exception. During the high-technology/dot.com boom that began in the late 1990s, unemployment in the county reached an all-time low of 1.3% in December 2000.

However, the feverish pace of growth subsided in 2001 and layoffs began to occur. The largest job losses were in the software industry, followed by the semiconductor and communications hardware manufacturing industry.[3] The current economic recession has been much deeper and persisted much longer than previously forecasted by economists.[6] The unemployment rate in Santa Clara County in December 2002 was 8.3%, compared to 6.6% for California.[7]

Figure 4



Source: California Employment Development Department, 2003 Benchmarks. Data not seasonally adjusted.

Unemployment & Job Growth

continued

The county unemployment rate reached a one-year high of 8.9% in October 2002, then dipped slightly to 8.8% in November and 8.3% in December 2002 (Figure 4). In January 2003, the county's unemployment rate rose to 8.8%, the highest unemployment rate among all counties in the Bay Area. California's unemployment rate was 7.1% in January 2003.[7]

Although economists remain optimistic about the long-term growth of jobs in Santa Clara County, the region is unlikely to match the pace of growth seen in the last few years. While job growth is expected to be limited until 2005, the long-term forecast shows significant changes. The Association of Bay Area Governments (ABAG) expects Santa Clara County to add 303,500 jobs in the next 25 years.[8] The Employment Development Department predicts that the six occupations with the fastest growth in Santa Clara County over the next few years to be system analysts, database administrators, computer support specialists, computer engineers, paralegal personnel and biological scientists.[7]

Poverty

Poverty status refers to the number and percentage of people living below the established national guidelines for poverty. The Census Bureau uses a set of income thresholds that vary by family size and composition to determine poverty status. If a family's total income is less than the threshold for a family of that size, then that family and every individual in it is considered as living in economic poverty. The poverty thresholds do not vary geographically, but they are updated annually for inflation using the Consumer Price Index (CPI-U). In 2001, the poverty threshold was $17,960 for a family of four.[9]

According to the 2000 Census, about 7% of individuals and 5% of families in the county lived below the poverty level. Of these families, nearly 8% had children under five years of age. Of families with female householder (no husband present), 14% were below the poverty level; of these, 26% had children under age 5. Furthermore, over 9% of all children under 18, 6% of the seniors over 65, and less than 1% of the population between 18 and 65 were below the poverty level.[10] However, it is important to note that the poverty threshold is not adjusted for regional variation or cost of living. Due to the high cost of living (about 1.5 times national estimates)[3] in Santa Clara County, these figures may not portray the entire spectrum of poverty in this county.

Household Income

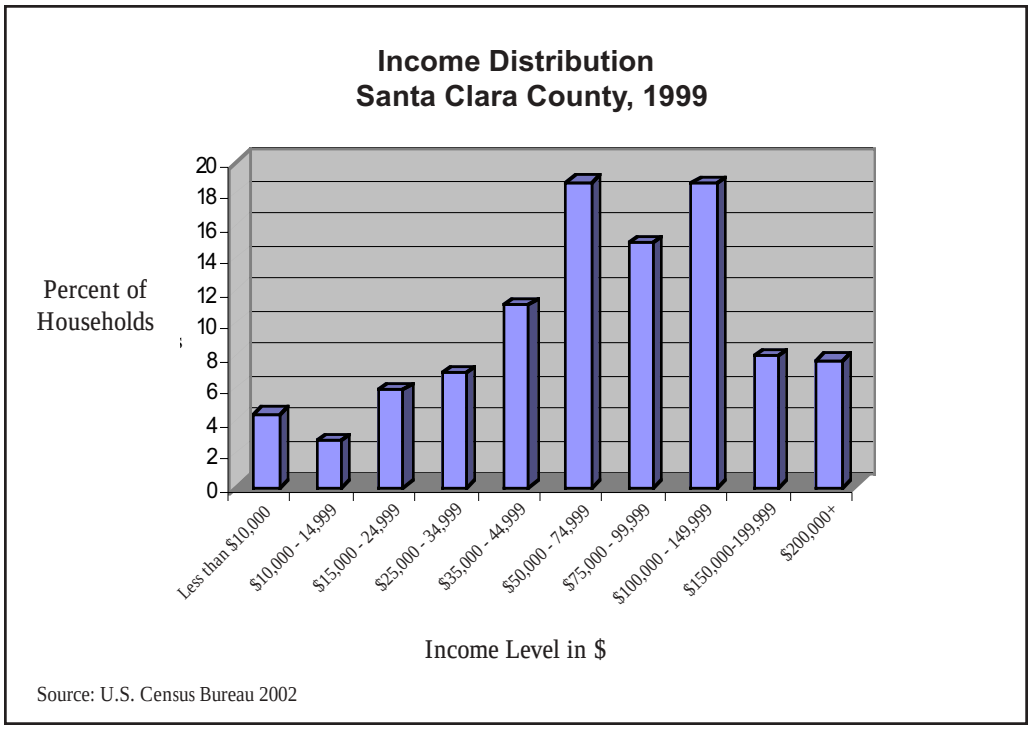
The median household income is the income at which half the households have an income above that level and half fall below. Areas with a higher cost of living have higher median household incomes than areas with a low cost of living.

Santa Clara County has one of the highest personal income levels in California. In 1999, Santa Clara County had the highest median household income ($74,335) of all California counties. California's median household income during the same year was $47,493. Additionally, Santa Clara County had the second highest median family income ($81,717) and fourth highest per capita income ($32,795) of all California counties.[11]

After adjusting for inflation, the median household income achieved modest gains over the last decade. Between 1989 and 1999, the county's median household income rose by 13%. During the same time period, about 7% of the population earned less than $15,000.[11]

In 1999, about 20% of county households earned less than $35,000. Households earning more than $100,000 in 2000 comprised 35% of the population (Figure 5).

Figure 5



Source: U.S. Census Bureau 2002

A living wage is defined as the amount of income required for a family to reach self-sufficiency (to meet basic needs without public or private assistance). The hourly self-sufficiency wage in Santa Clara County for a single adult with two children in 2003 is $21.64. Approximately 60% of the ten jobs with the greatest projected growth in the County currently pay this amount or more.[12] Half of these jobs, such as computer engineers and biological scientists, require at least a bachelor's degree.[13]

Free/Reduced Meals in Schools

The number of children receiving free and reduced-cost lunches is sometimes used as a proxy measure of the number of children in low-income families. During the 2001-2002 school year, 27.3% of Santa Clara County school children received free or reduced cost school lunches, compared to 47.1% statewide. Students in public schools receiving free/reduced lunches decreased slightly between 1996 and 2001, from 75,596 to 67,881.[14]

Housing

Over the past decade, Santa Clara County has experienced rising housing costs and a decrease in available homes. Although the increase in housing costs has slowed, housing ownership continues to be out of reach for many Santa Clara County residents. Affordable housing is essential to economic well-being, job recruitment and retention. Housing creates jobs, increases local tax revenues and enables our community to live, work, and conduct business. Housing indicators examined in this section include homelessness, average household size, home ownership, and home rental.

Average Household Size

The average household size is the total population in households divided by the total occupied households. In 2000, Santa Clara County's average household size for owner-occupied housing was 3.14, and for renter-occupied units was 2.72, resulting in an overall average of 2.96. [15]

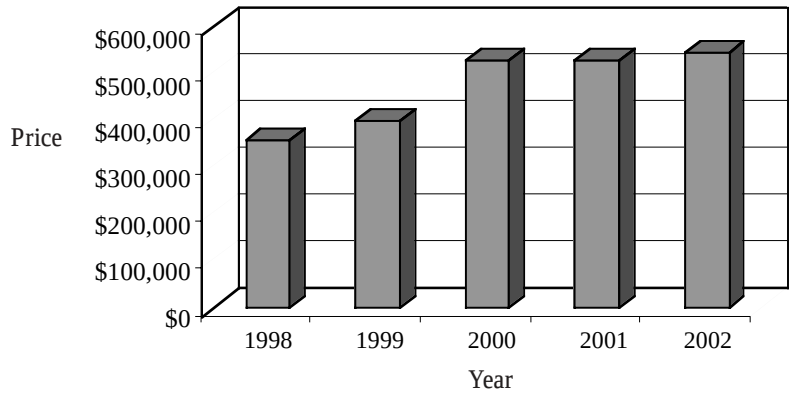
The incidence of overcrowding for the city of San Jose, which is considered occupied housing with more than one person per room, has increased significantly in the last few years, jumping from 14.2% in 1990 to 18.3% in 2000. Renter occupied units in San Jose constituted the majority of overcrowded housing in 2000 (61.2%).[16]

Owning a Home

Indicators of home ownership include the number of people who own homes, median prices of homes, and housing affordability. Overall, 59.8% of the housing units in Santa Clara County were owner occupied in 2000, compared to the state average of 56.9%. County residents living in owner occupied housing units totaled 1,010,939 in 2000. The majority of owner-occupied housing unit residents purchased their homes before 1995. Only 36% of County owner-occupied housing unit residents moved into their homes between 1995 and 2000.[1]

The median price of homes in Santa Clara County, which is a measure of change in market activity, has increased over the past five years, with single-family residential property increasing from $355,000 in 1998 to $545,000 in 2002 (Figure 6). Los Altos Hills had the highest median price for a single-family home ($2.5 million) in December 2002. The lowest median price ($449,950) for a single family home in the County was in Gilroy. The median price of all Santa Clara County residential properties in December 2002 was $479,000, up about 9% from $459,000 the previous year, and higher than California's median price of a home ($338,110) during the same time period.[17, 18]

Figure 6



Source: 2001 Annual Real Estate Report, Santa Clara County

Owning a Home continued

The Housing Affordability Index (HAI) for June 2002, which measures the percentage of households that can afford to purchase a median priced home, indicated that 27% of the Santa Clara County residents were able to afford a median priced home in the third quarter of 2002. This is a significant increase from a level of 18% in 2000, but much lower than national rate of 56%.[19] The overall California HAI rate for February 2003 was 31%, down five points from the same time the previous year.[20]

Renting a Home

In 2000, 631,958 residents in Santa Clara County lived in rental units. Of these renters, 76% had lived in rented units since at least 1995. Trends suggest that the high cost of real estate has resulted in more people renting than buying homes in the last five years.[1] Apartment rental prices soared 29% between 1998 to 2001, not taking into consideration the overall inflation.[21]

Despite the high local rental rates, Santa Clara County recently has had the largest drop in apartment rental rates in the entire west coast of the United States. Average rents in Santa Clara County fell by 3.8% between September and December 2002, from $1,427 to $1,372.19. The current economic recession along with increased apartment construction have contributed to the lower rents.[22]

Homelessness

Homelessness is a complex issue that encompasses many areas, including housing, basic daily needs, health, workforce development, education, and public safety. In short, a person is considered homeless when he or she "lacks a fixed, regular, and adequate nighttime residence." Some of the major causes of homelessness include lack of affordable housing, economic factors, domestic violence, substance abuse, and mental illness.[23] A Santa Clara County Homeless Survey conducted in 1999 showed that there were an estimated 20,000 homeless people in Santa Clara County, of which one third were children.[24]

A separate study of homeless individuals in Santa Clara County was conducted by government and homeless shelter representatives in 1995. Results showed that 23% of homeless were children, of which 65% were younger than 12 years of age. Approximately 26% of families with children reported being homeless for more than a year. Fifty-one percent of homeless surveyed were persons of color, 34% of which were Hispanic. Furthermore, 33% had alcohol/drug abuse problems, 11% had mental illnesses, and 8% had both. Regardless of characteristics of the homeless population, programs agreed that more shelter beds for homeless were needed.[25]

Transportation

Traffic in and out of Santa Clara County is a large concern in the Bay Area. Transportation methods used by residents and commuters dominate community and local government discussions and transportation planning. Workers from all wage ranges who cannot afford to live in Santa Clara Valley must commute up to five hours per day. This results in increased air pollution, traffic congestion, stress, and loss of productivity. Indicators that influence transportation in Santa Clara County include the number of licensed drivers and registered vehicles and the use of public transportation.

Licensed Drivers & Registered Vehicles

The high volume of drivers on Santa Clara County streets contributes to the area's traffic congestion. Although a portion of county drivers are commuters from out of town, most are local. In 2001, there were a total of 1,166,089 licensed non-commercial drivers for vehicles in Santa Clara County in 2001; of these, 42,911 were between 16 and 19 years of age.[26] Furthermore, there were 1,108,428 registered automobiles in Santa Clara County. The total number of registered vehicles per household for the year 2000 was 1.96.[27]

Forms of Transportation

The average travel time to work in the year 2000 was 26.1 minutes in Santa Clara County, up about 14.5% from two decades ago.[28] Currently in 2003, the average Daily Vehicle Miles Traveled (DVMT) is about 18.6 miles in the county.[12]

In Santa Clara County, 77.3% (641,113) of the working population drive alone to work each day, increasing the traffic congestion and contributing to air pollution. About 12% (101,188) carpool to work, a percentage that has remained relatively steady in the last few years. Three and a half percent of the population (29,118) use public transit; 2% (14,768) walk to work; 3% (25,868) work from home; and 2% (16,854) use other forms of transporta–tion.[29]

Health & Well-Being

Access to Health Care

Access to a comprehensive health insurance program and health care are important determinants for children's health outcomes and successful learning. Important indicators of adequate health care access are health care insurance coverage, use of health services, and use of dental services.

Health Care Insurance Coverage

According to a California study conducted in 2001 by the UCLA Center for Health Policy Research, uninsured children are ten times less likely to have a regular health care provider, four times more likely to delay seeking needed care, and six times less likely to fill a prescription than those with insurance. Furthermore, the study found that lack of insurance reduces a child's access to immunizations, well-baby care, childhood checkups, and genetic/chronic disease screening for infants, preschoolers, and school-age children. Adolescents without health insurance have limited access to health education and prevention services aimed at reducing high-risk behaviors. Most children are dependent on their parents for access to the health care system and for payment of health care services.[30]

The Children's Health Initiative, approved by the Santa Clara County Board of Supervisors in December 2000, aims to make health insurance available to 100% of the children living in Santa Clara County whose family income is at or below 300% of the Federal Poverty Level (FPL). Insurance programs that are included in the Children's Health Initiative are Healthy Kids, Medi-Cal, and Healthy Families.

Table 1
Percent of Uninsured Children Age 0-17 in 2001

Santa Clara County	3.1
California	9.6
Healthy People 2010 Objective	NA

Source: UCLA Center for Health Policy Research, 2002

The rate of uninsured children 0-17 years in the county in 2001 was 3.1%, much lower than California's rate of 9.6%.[30] Furthermore, the number of children enrolled for medical coverage has increased since the inception of the Children's Health in January 2001. As of January 2003, the Children's Health Initiative facilitated the enrollment of 49,046 children for medical, dental, and vision care coverage.[31]

Use of Health Services

BACKGROUND

Routine and periodic visits to a health care provider promotes children's general well-being and growth, prevents health problems, and provides opportunities for early intervention when problems arise. Recommended immunizations and regular check-ups with a pediatrician or local health clinic are important ways to maintain children's health.[32]

HOW ARE WE DOING?

Table 2
Percent of Children Age 0-17 Years with Ongoing Health Care

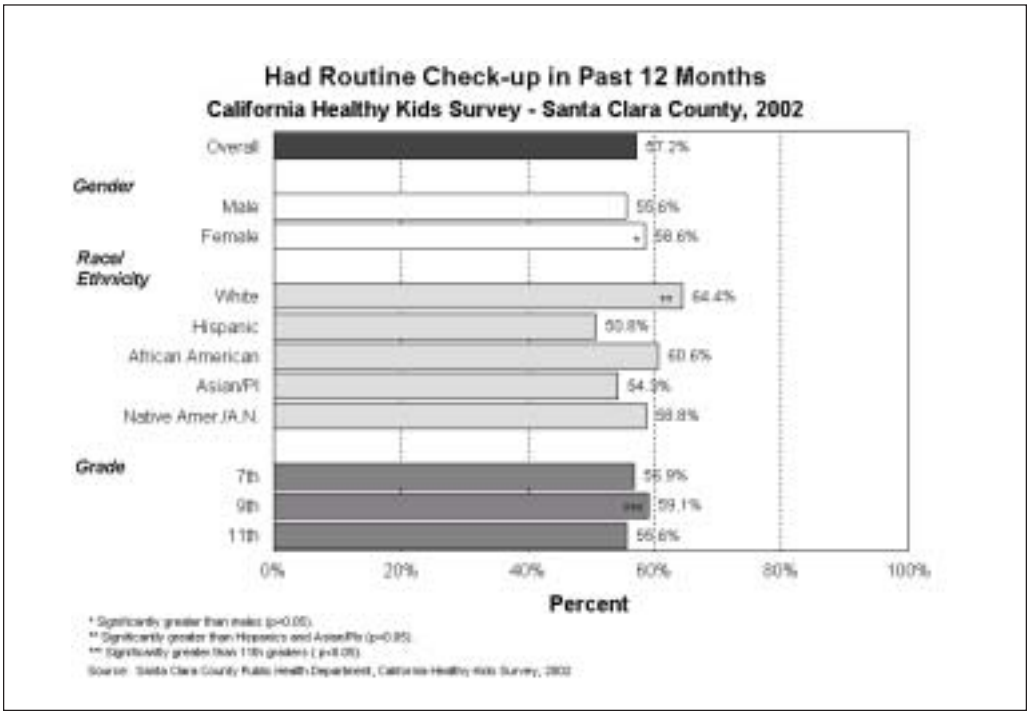
Santa Clara County 2001	93
California	NA
Healthy People 2010 Objective	97

Source: UCLA Center for Health Policy Research, 2002

KEY FINDINGS

An estimated 93% of children in Santa Clara County ages 0 to 17 have a specific source of ongoing health care.[30] Overall, 57% of the children in Santa Clara County reported that they had a routine medical check-up in past 12 months (Figure 7). More females than males had a checkup. A higher proportion of Whites had checkups than Hispanics and Asian/PIs. More Hispanic and African American females had a routine checkup than males in the same groups (data not shown). A significantly larger number of 9th graders had checkups in the past year than 11th graders.

Figure 7



Use of Dental Services

Oral health is an important part of children's health and affects how children feel and behave. Poor oral health has been related to poor performance in school, poor social relationships, and reduced success later in life. Having dental caries (tooth decay) is the single most common chronic childhood disease, and is five times more common than asthma and seven times more common than hay fever. Untreated dental caries can also result in inadequate nutrition and speech problems. Regular dental visits can prevent oral health problems, and allow early detection and treatment of dental problems. The American Academy of Pediatrics has recommended that a child's first dental visit should occur when a child is one year of age and every six months thereafter.[33]

Medical insurance is a strong predictor of access to dental care. Uninsured children are 2.5 times less likely than insured children to receive dental care.[33]

Children in families without dental insurance are three times more likely to have dental needs than children with either public or private dental insurance. For each child in the U.S. without medical insurance, there are at least 2.6 children without dental insurance.[34]

Table 3
Oral Health Indicators

	Percent of 3rd Graders with a History of Tooth Decay	Percent of 3rd Graders Who Visited a Dentist in the Past Year	Percent of Children without Dental Insurance
Santa Clara County 2001	72	83	16
California	NA	NA	NA
Healthy People 2010 Objective	42	83	NA

Source: The Health Trust, 2001

Use of Dental Services continued

KEY FINDINGS

According to the CHKS survey results, more than 80% of Santa Clara County children reported that they had visited a dentist in the 12 months prior to the survey (Figure 8). Females were significantly more likely to have been to the dentist than males. Whites were more likely than members of any other ethnic group to have had a checkup in past 12 months, but more White, Hispanic, and Asian/PI females visited the dentist than males in those same ethnic groups. More 9th graders than 7th or 11th graders had seen a dentist.

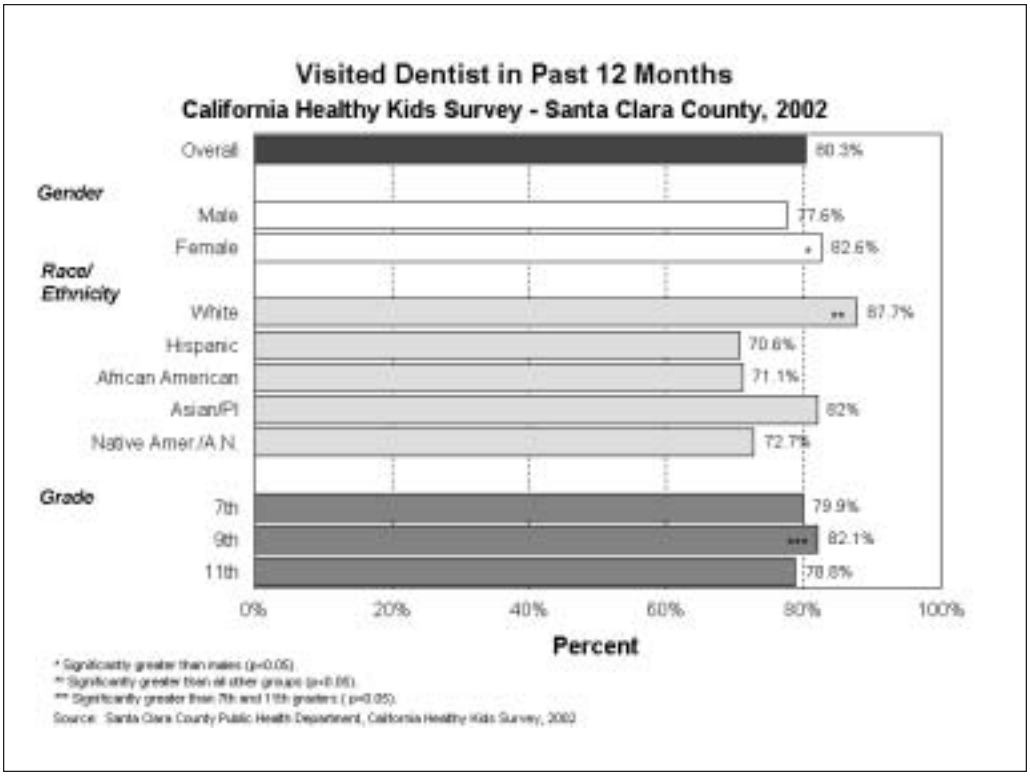
Results from the Health Trust's dental needs assessment showed that slightly more children in the Head Start program and in the third grade visited a dentist in the past year than those in kindergarten. Main reasons for not visiting a dentist in the past year were parents feeling there was no reason for their child to visit a dentist or cost. Some parents also believed that their children were too young to see a dentist (see Table 4).[35]

Among Kindergarten-aged children, higher proportions of Asian (82%) and White (79%) children had visited a dentist in the past year than Hispanic children (26%). In addition, more kindergarten children who were not eligible for the free lunch program at school (82%) had received dental services in the past year compared to lower income children eligible for free lunch (69%). Similar trends were seen among third graders as well.[35]

The Health Trust survey in 2001 also revealed that approximately 16% of children in Santa Clara County did not have dental insurance (Table 3). Furthermore, Hispanic children were twice as likely to not have dental insurance compared to White and Asian children.[35]

Among third grade children, approximately 72% had a history of tooth decay. Hispanic and Asian children were more likely to have untreated decay than White children.[35]

Figure 8



Use of Dental Services continued

Table 4
Accessing Dental Services in Santa Clara County in 2001

	Have Been to Dentist in Past 1 Year	Have Never Been to a Dentist	Reasons for Not Visiting a Dentist in the Past 1 Year
Head Start Children	82%	13%	Parents felt child too young (28%), no reason to go (26%), cost (21%)
Kindergarten Children	75%	18%	No reason to go (42%), cost (27%), parents felt child too young (15%), do not have or know dentist (15%)
Third Grade Children	83%	3%	Cost (38%), no reason to go (30%), do not have or know a dentist (12%)

Source: The Health Trust, 2001

Early Childhood

A healthy early childhood fosters cognitive, physical and psycho-social growth as well as the development of skills and assets that are important for a child's general health and emotional well-being. At a community level, infant health is of critical importance because it serves as a predictor of the overall health of the next generation. Important indicators that help evaluate children's health in their early years are prenatal care, birth weight, breast-feeding rates, infant mortality rates, prevalence of neural tube defects, blood lead levels in children, and immunization rates.

Early and Adequate Prenatal Care

BACKGROUND

Prenatal care is provided to pregnant women to prevent complications and reduce incidence of maternal and infant mortality. It typically includes three components: risk assessment, treatment for medical conditions or risk reduction, and education. Prenatal care reduces perinatal illness, disability and death by identifying and mitigating potential risks and helping women address behavioral factors that contribute to poor birth outcomes, such as tobacco and alcohol use. Early prenatal care, beginning in the first trimester, can prepare both mother and child for a healthy pregnancy and birth outcome.

HOW ARE WE DOING?

Table 5
Percent of Mothers Who Receive Prenatal Care Beginning in the First Trimester of Pregnancy

Santa Clara County 2000*	86.6
California 2000**	84.5
Healthy People 2010 Objective	90.0

* Santa Clara County Public Health Department, Birth Records, 2000
** California Department of Health Services, Birth Records, 2000

KEY FINDINGS

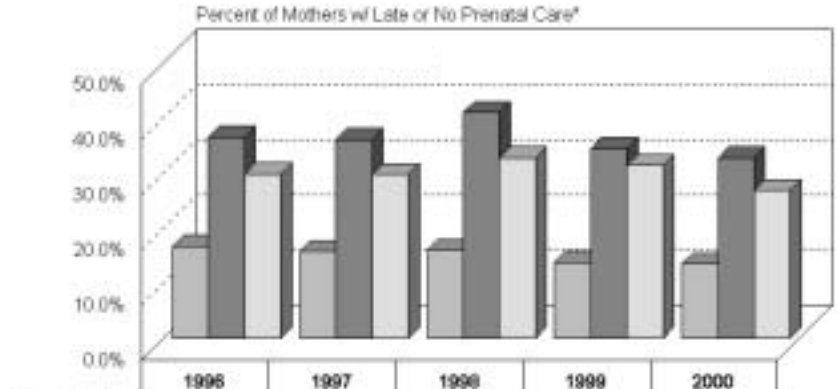
Santa Clara County has yet to achieve the national Healthy People 2010 objective for providing prenatal care. County data suggests that teenage mothers are at particular risk for poor birth outcomes in the absence of prenatal care. These findings are consistent with national data.[36]

Between 1996 and 2000, the proportion of overall births in the county that received late or no prenatal care decreased (Figure 9). Yet about 33% of births to teen mothers age 12 to 17 received late or no prenatal care. Similarly, close to 27% of births among 18 to 19-year old teen mothers received inadequate prenatal care.

Early and Adequate Prenatal Care continued

Figure 9

Percent of Adolescent and Adult Births with Late or No Prenatal Care
Santa Clara County, 1996-2000



	1996	1997	1998	1999	2000
County Total	16.6%	15.7%	15.9%	13.7%	13.4%
Age 12-17	36.4%	36.0%	40.9%	34.3%	32.6%
Age 18-19	29.7%	29.6%	32.6%	31.3%	26.7%

* Late or No Prenatal Care is prenatal care beginning after the first trimester, or not at all.
Percent calculated among each age group.
Source: Santa Clara County Public Health Department, Birth Records, 1996-2000.

Birth Weight

BACKGROUND

Birth weight is an important indicator of an infant's overall health. A healthy birth weight is 2,500 grams or more, or about 5.5 pounds. An infant with low birth-weight weighs less than 2,500 grams, and an infant with very low birth-weight weighs less than 1,500 grams or about 3.3 pounds. Low birth-weight babies are at a much greater risk of death, disease and disability. Disabilities related to low birth-weight include cerebral palsy, learning disabilities, visual problems, and respiratory problems, all of which may continue throughout life. Factors contributing to low and very low birth-weight include maternal age (over 45 years and under 20 years), multiple births, socioeconomic status, poor nutrition, smoking, alcohol consumption, drug use, and reduced access to health services such as prenatal care.[36]

HOW ARE WE DOING?

Table 6
Birth Weight

	Percent of Babies Low Birth Weight	Percent of Babies Very Low Birth Weight
Santa Clara County 2000*	6.1	1.0
California 2000**	6.2	1.1
Healthy People 2010 Objective	5.0	0.9

* Santa Clara County Public Health Department, Birth Records, 2000

**California Dept of Health Services, Maternal and Child Health Branch, 2000

KEY FINDINGS

Santa Clara County has yet to meet the national Healthy People 2010 Objective for reducing the percentage of babies born with low birth-weight. From 1996 to 2000, the percent of low birth-weight babies for all county residents remained stable around 6% (Figure 10) and the percent of very low birth-weight babies has remained around 1.0% for all mothers (Figure 11). County data for the year 2000 suggest that teenage mothers are at greatest risk for having babies born at low birth-weight. Over 9% of infants born to mothers between age 12 and 17 suffered from low birth-weight, and 1.5% of infants born to teenage mothers age 12 to 17 had very low birth-weights. These findings are similar to national data.[37]

Birth Weight continued

Figure 10

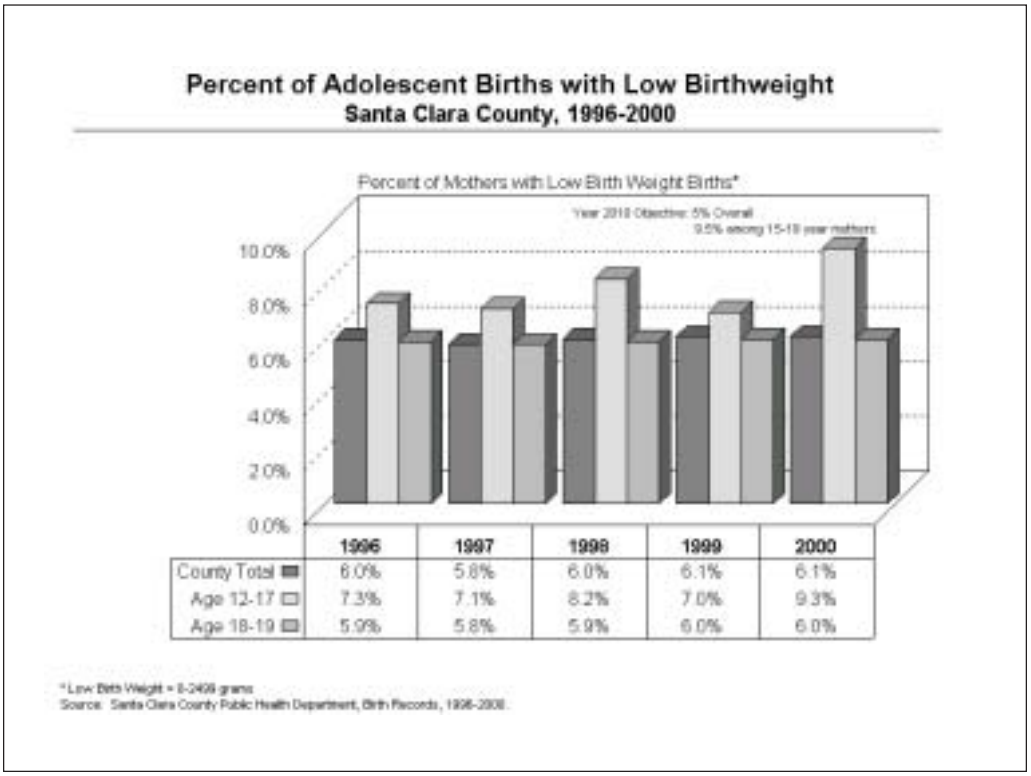
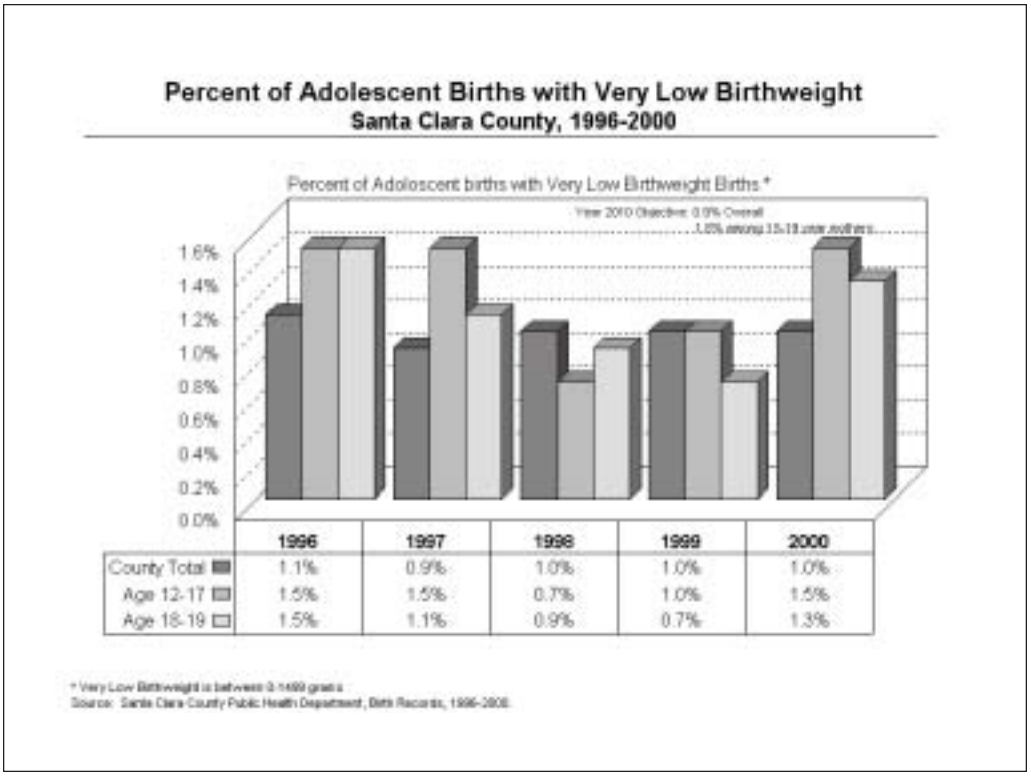


Figure 11



Breast Feeding

Breast milk is acknowledged as the most complete form of nutrition and a good source of immunity against common diseases for infants. The benefits of breastfeeding are tremendous – it is known to reduce occurrences of diarrhea, respiratory infections, and ear infections, in addition to reducing families' economic burdens.

There is limited data on the prevalence of breastfeeding in Santa Clara County. The data presented here are from a survey that was conducted on Women, Infants, and Children (WIC) clients in 2001. Also included is data released by the California Department of Health Services (CDHS) on mothers who were discharged from Santa Clara County hospitals in 1999 and 2000.

Table 7
Breast Feeding

	Percent of Babies Short-Term Breastfed (Breastfeeding postpartum)	Percent of Babies Long-Term Breastfed (Breastfeeding at 6 mos.)
Santa Clara County 2001 WIC Survey* (breastfed and stopped)	40	37
Santa Clara County 2000 Hospital Data** (breastfed exclusively at discharge)	53	NA
California 2000**	43	NA
Healthy People 2010 Objective	75	50

*Santa Clara County Public Health Department; Women, Infants & Children, 2001

** California Department of Health, 2002

According to the data released by the California Department of Health, breastfeeding rates among Santa Clara County mothers at time of hospital discharge were ranked 40th out of 58 counties in the state for breastfeeding exclusively and 21st in the state for any breastfeeding practices.[38] There is a serious lack of county-wide breastfeeding data, which is needed to better understand the prevalence and trends related to breastfeeding practices.

Infant Mortality

BACKGROUND

The infant mortality rate (number of deaths per 1,000 live births) is the proportion of babies who are born in a given year and die within their first year of life. Infant mortality rate is a critical indicator of a population's health. Infant mortality rates reflect the overall state of maternal health as well as the quality and accessibility of primary health care available to pregnant women and infants. Despite steady declines in the 1980s and 1990s, the rate of infant mortality in the United States remains among the highest in the industrialized world.[36]

HOW ARE WE DOING?

Table 8
Infant Mortality Rates
Number of Deaths per 1,000 Live Births

	Infant Mortality*	Neonatal Mortality*	Perinatal Mortality*
Santa Clara County 2000**	4.6	3.4	3.9
California 2000***	5.4	3.7	9.5
Healthy People 2010 Objective	4.5	2.9	1.5

*Note: See glossary for definitions.

**Santa Clara County Public Health Department, 2000

***California Department of Health Services, Birth and Death Records, 2000

KEY FINDINGS

Santa Clara County has yet to meet the Healthy People 2010 Objective for reducing its infant mortality rate. Disparities in infant mortality exist across race and ethnicity, maternal age, and infant birth weight.

Infant mortality rates declined among both males and females between 1996 and 2000 (Figure 12). Though male infants had higher mortality rates than females, the mortality rate among males stabilized between 1999 and 2000.

Disparities among racial and ethnic groups are noted in Figure 13. Over the past five years, infant mortality rates for Hispanics were significantly higher than rates for Whites/Others or Asian/PIs. The infant mortality rate for Hispanics in 2000 was 6.0, well over the Healthy People 2010 Objective of 4.5 deaths per 1,000 live births.

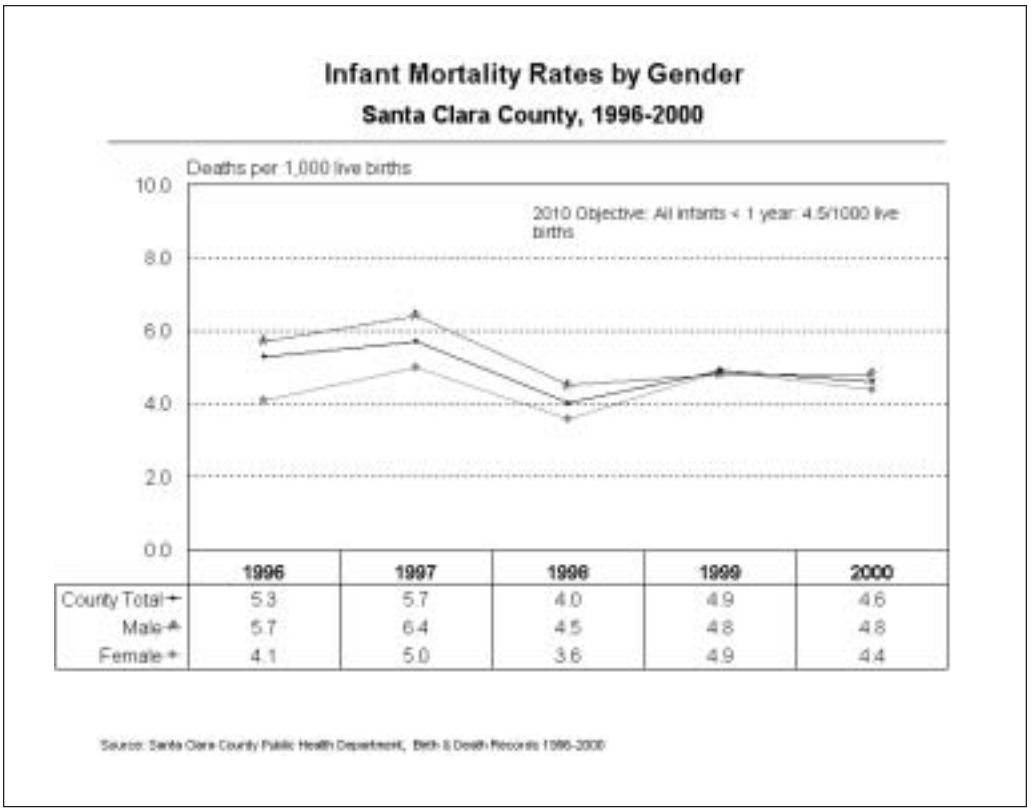
The infant mortality rate among African Americans was estimated to be 12.2 deaths per 1,000 live births. However, the data were not graphed because the rates were considered unreliable due to the small numbers of African Americans in the Santa Clara County population.

Post-neonatal (28 to 364 days old) mortality rates for the county declined from 1996 to 2000 (Figure 14). Since 1998, the rates have been consistently lower than the Healthy People 2010 Objective of 1.5 deaths per 1,000 live births. No significant trends were observed among perinatal (20 or more weeks gestation) and neonatal (full-term infants 0 to 27 days old) mortality rates.

The number of deaths among infants under one year of age declined from 1996 to 2000 (Figure 15). Between 1996 to 2000, the number of infant deaths due to maternal complications and SIDS also declined.

Infant Mortality

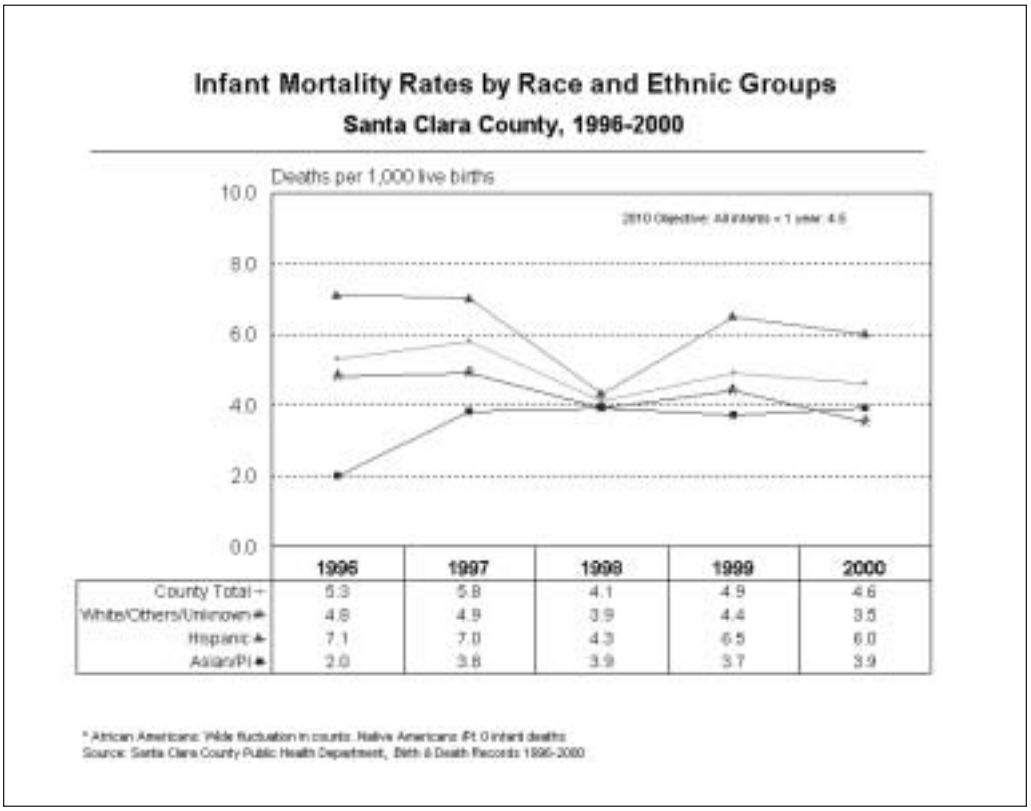
Figure 12



	1996	1997	1998	1999	2000
County Total	5.3	5.7	4.0	4.9	4.6
Male	5.7	6.4	4.5	4.8	4.8
Female	4.1	5.0	3.6	4.9	4.4

Source: Santa Clara County Public Health Department, Birth & Death Records 1996-2000

Figure 13



	1996	1997	1998	1999	2000
County Total	5.3	5.8	4.1	4.9	4.6
White/Others/Unknown	4.8	4.9	3.9	4.4	3.5
Hispanic	7.1	7.0	4.3	6.5	6.0
Asian/PI	2.0	3.8	3.9	3.7	3.9

* African Americans: Wide fluctuation in counts. Native Americans: 0-1 infant deaths
Source: Santa Clara County Public Health Department, Birth & Death Records 1996-2000

Infant Mortality continued

Figure 14

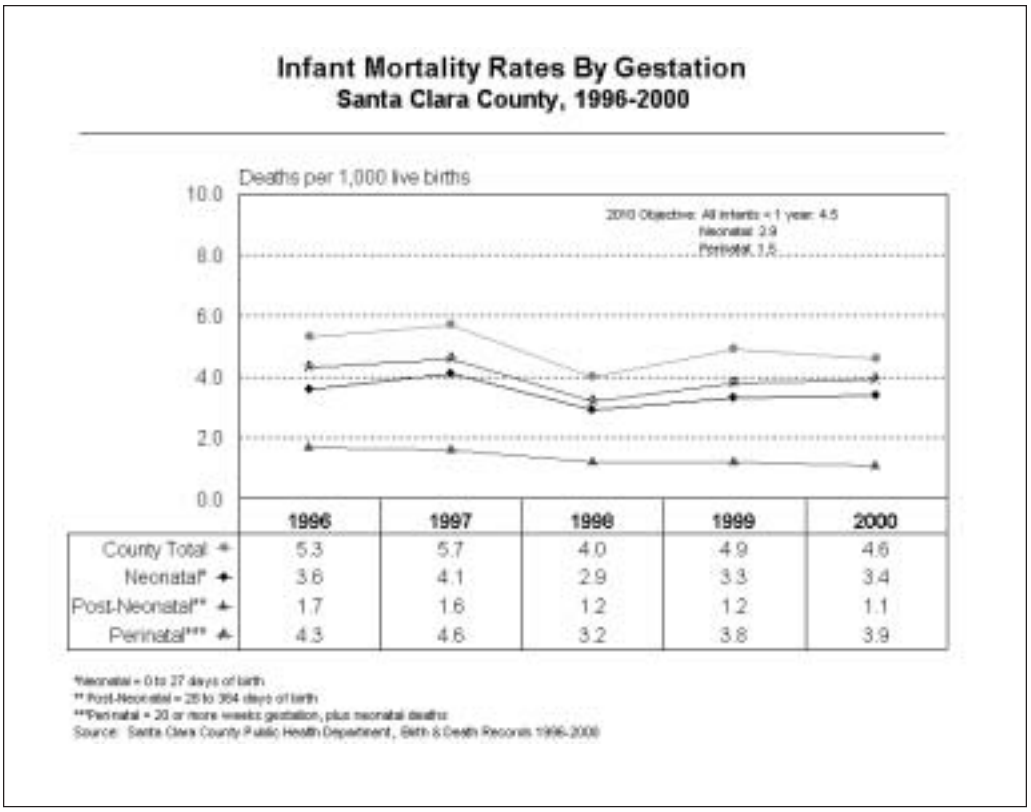
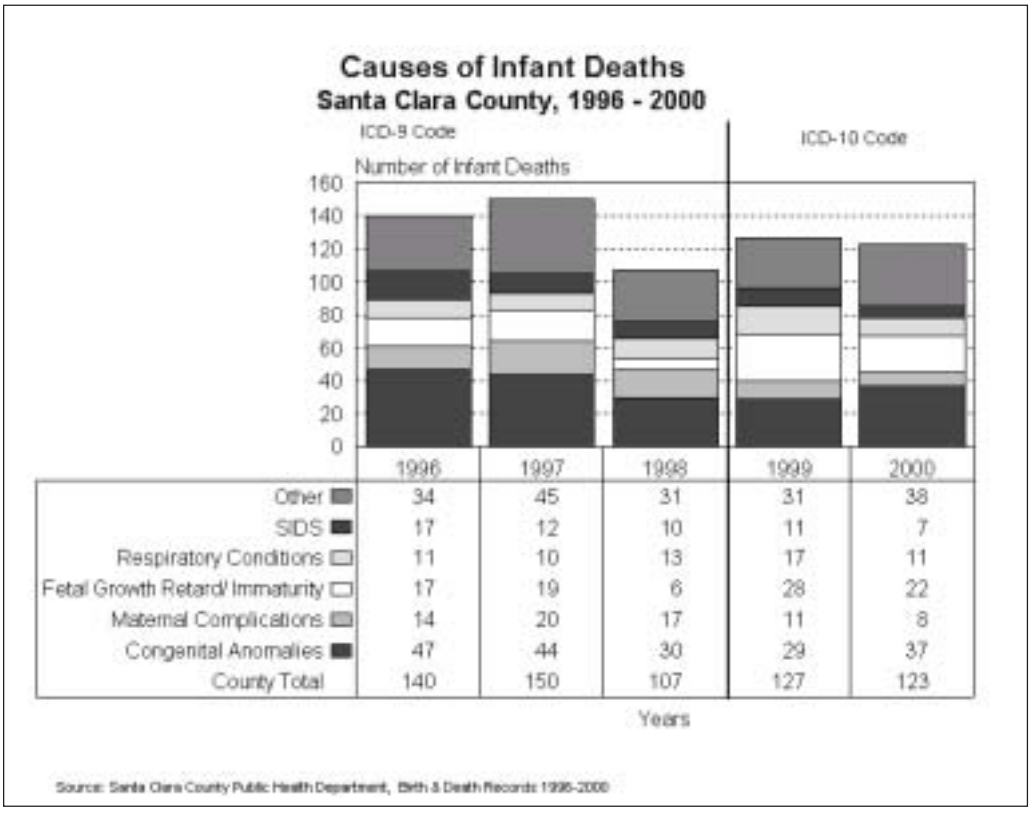


Figure 15



Neural Tube Defects

BACKGROUND

Neural tube defects (NTDs), such as spina bifida and anencephaly, are birth defects that occur when the fetal neural tube (precursor to the brain and spinal cord in human embryos) fails to close fully, interrupting the development of the nervous system. Although NTDs are caused by genetic and environmental factors, studies have shown that folic acid (also folate or folacin) can reduce the prevalence of NTDs when consumed prior to pregnancy. Folic acid is a B vitamin found in green leafy vegetables, beans, orange juice and enriched foods such as breads, pasta, rice and cereals. The Centers for Disease Control recommends that women consume 400 micrograms of folic acid per day prior to conception, which has shown to decrease the incidence of NTDs by 50%.[39]

HOW ARE WE DOING?

Table 9
Spina Bifida Rates (Per 10,000 Live Births)

Santa Clara County (Average of births from 1995 – 1999)	5
California (Average of births from 1995 – 1999)	5
Healthy People 2010 Objective	3

Source: California Birth Defects Monitoring Program, 2000

KEY FINDINGS

Although recent data shows that Santa Clara County's rate of NTDs is equivalent to California,[16] the County has yet to meet the Healthy People 2010 Objective of reducing rate of spina bifida to three per 10,000 live births.

According to the data results from the County Public Health Department's Adult Behavioral Risk Factor Survey in 2000, only half of adult women of childbearing age (18 to 44 years) reported consuming folic acid, which is far below the Healthy People 2010 target of 80%. Further analysis suggests disparities among various ethnic groups, education levels, and income levels. Folic acid intake among Hispanic women was extremely low. Additionally, other important risk factors associated with lack of folic acid intake were being young, having less years of education, being in a lower income level, and not receiving routine physical checkups. The survey results also suggested that a large number of respondents were not aware that folic acid consumption by women of childbearing age helps in preventing specific birth defects, such as neural tube defects.[40]

Elevated Blood Lead Levels

Childhood lead poisoning (exceeding 10 micrograms/dL blood lead) is considered one of the most preventable environmental diseases in young children, yet approximately one-half million children in the United States have elevated blood levels. Lead poisoning can cause irreversible damage in children, such as learning disabilities, behavioral problems, and, at very high levels, seizures, coma and even death.[41]

Children at highest risk for lead poisoning are between the ages of six months and six years, especially those who are one-to-two years old, are living in poverty, and live in pre-1978 homes with deteriorating paint or in homes that have been recently remodeled or painted. Approximately 12,000 children age one to five live in homes built prior to 1950, homes that contain the highest percentage of lead in paint. Environmental sources of lead exposure include lead in dust and soil; home exposure (painting or remodeling, radiator or battery repair, demolition or metal casting); and hobbies that use lead (stained glass, fishing sinkers, target shooting, and ceramics). Prevention efforts should focus on lead source abatement and eliminating children's exposure.[42]

Table 10
Number of Children with Elevated Blood Lead Levels

Santa Clara County 2002	~5,900
California	NA
Healthy People 2010 Objective	0

Source: Santa Clara County Public Health Department Childhood Lead Poisoning Prevention Program, 2002; National Health and Nutrition Examination Survey 1988-1994, Part III, Phase II (NHANES III)

Based on the National Health and Nutrition Examination Survey 1988-1994, Part III, Phase II (NHANES III) data and California population projections, the Santa Clara County Lead Poisoning Prevention program estimated that 5,900 children age one-to-five in the County have blood lead levels greater than 10 micrograms/dL.[42]

Santa Clara County has yet to meet the Healthy People 2010 Objective for elevated blood lead levels in children. From January 1990 to March 2000, the Santa Clara County Childhood Lead Poisoning Prevention Program identified 740 cases of childhood lead poisoning. Of those, 244 (33%) had blood levels between 20 to 44 micrograms/dL, 84% of the cases were among Hispanic children, 420 (54%) were younger than two years old, and 242 (33%) were between the ages of three and four.[42]

Immunization & Vaccine Preventable Diseases

BACKGROUND

Immunizations help protect children against illness, disability, and death caused by common infectious diseases that are vaccine preventable. These diseases, such as measles, rubella (German measles), mumps, diptheria, and tetanus (lockjaw), can lead to serious and even life threatening complications. However, in recent years, the incidence of these diseases has declined to record lows because of increased access to vaccinations made possible by a national immunization campaign. Other diseases that childhood vaccines prevent are polio, pertussis (whooping cough), Heamophilus influenza type b (Hib disease – a major cause of bacterial meningitis), hepatitis B, varicella (chickenpox), and pneumococcal (causes bacterial meningitis and blood infections).

The cost effectiveness of administering vaccinations has been well documented. Estimates in 1994 showed that for every dollar spent to administer the oral poliovirus vaccine, $3.40 was saved in direct medical costs and $2.74 in indirect societal costs. In addition, for every dollar spent to purchase measles vaccine, $10.30 was saved in direct medical costs and $3.20 in indirect societal costs.[43]

Other studies showed the cost effectiveness of vaccines for hepatitis B, MMR (measles, mumps, and rubella), Hib, DtaP (diptheria, tetanus, acellular pertussis), and varicella. For example, there is a return investment for direct medical savings from $0.50 on the dollar for infants immunized for hepatitis B to over $10 for MMR immunization. A routine varicella vaccination program for healthy children would also save $5 for every $1 invested in the vaccination.[44]

The implementation of an electronic immunization registry is underway in Santa Clara County, with the goal of monitoring the immunization status of all children in the county. As of January 2002, more than 150,000 children had their immunization histories in the registry. Once all immunization providers are enrolled in the registry, children's immunization coverage can be assessed and updated at every opportunity, ultimately resulting in improved immunization coverage rates.

HOW ARE WE DOING?

Table 11
Percent of Up-to-Date Vaccinations

	Kindergarten* Retrospective Survey (2002) Age 0 - 2 Years	National ** Immunization Survey (2002) Age 0 - 2 Years	7th Graders*** (2001)
Santa Clara County	75.1	77.1	72.9
California	72.2	71.7	70.0
Healthy People 2010 Objective	90.1	NA	NA

* Kindergarten Retrospective Study, 2002

** National Immunization Survey, 2002

***Santa Clara County Public Health Department Immunization Program, 2002

Immunization & Vaccine Preventable Diseases continued

KEY FINDINGS

According to the Kindergarten Retrospective Survey, county immunization rates increased from 72% to 75% between 1999 and 2002 (Figure 16). The increase was seen among all groups, most significantly among African-Americans. Hispanic children had the lowest immunization coverage; only 65% of Santa Clara County's Hispanic children were immunized in 2002. Overall, Santa Clara County has yet to meet the Healthy People 2010 Objective for immunization (Table 11).

According to the National Immunization Survey, Santa Clara County was second in the nation to Florida's Miami-Dade County for achieving a high rate (77.1%) of immunization coverage during the third quarter of 2001 through the second quarter of 2002 for the 4:3:1:3:3 immunization series. Santa Clara County's rate of 77.1% was a 7.9% increase from the previous year and was 5.4% above California's immunization rate. This series of immunizations include four or more doses of diptheria and tetanus toxoids and pertussis vaccine (DTP); three or more doses of poliovirus vaccine (polio); one or more doses of any measles-containing vaccine (MCV); three or more doses of Haemophilus influenzae type b vaccine (Hib); and three or more doses of hepatitis B vaccine (Hep B).[45]

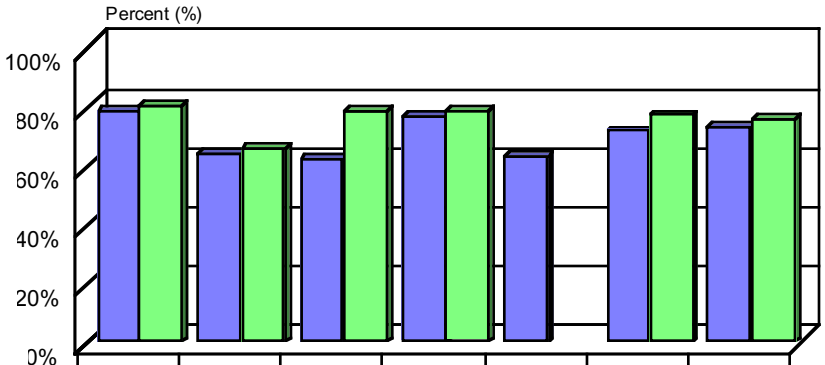
In 2001, 73% of all 7th graders had all required immunizations (three Hep B, two MMR), which is 3% above the State of California average of 70%.[45]

Since 1993, the rate of reported pertussis in children 0-4 years of age in Santa Clara County has been between nine and 40 cases per 100,000 residents. There was a small pertussis outbreak in 1998, after which the rate returned to baseline levels (Figure 17). In the past 10 years, there have been few cases of vaccine-preventable diseases: one congenital rubella syndrome, one diptheria, nine measles, one poliomyelitis, and three tetanus. There was a rubella outbreak in 1996 where 26 cases emerged; however, since then, there have been no new cases of rubella reported (Figure 18).

Figure 16

Proportion of Kindergarteners Who Were Up-to-Date* With Vaccinations at 24 Months, 1999 & 2002

By Race/Ethnicity



	White	Hispanic	Black	Asian	Amer. Indian	Other/Unk.	All
1999	77.9%	63.4%	62.1%	76.3%	62.5%	71.7%	72.3%
2002	79.8%	65.1%	77.8%	77.7%	N/A	76.8%	75.1%

• Up-to-date for 4 DTP, 3 Hep B, 1 MMR by second year

Source: Santa Clara County Public Health Department: Immunization Program; California Department of Health Services, Immunization Branch, Kindergarten Expanded Retrospective Survey, 1999-2002

Figure 17

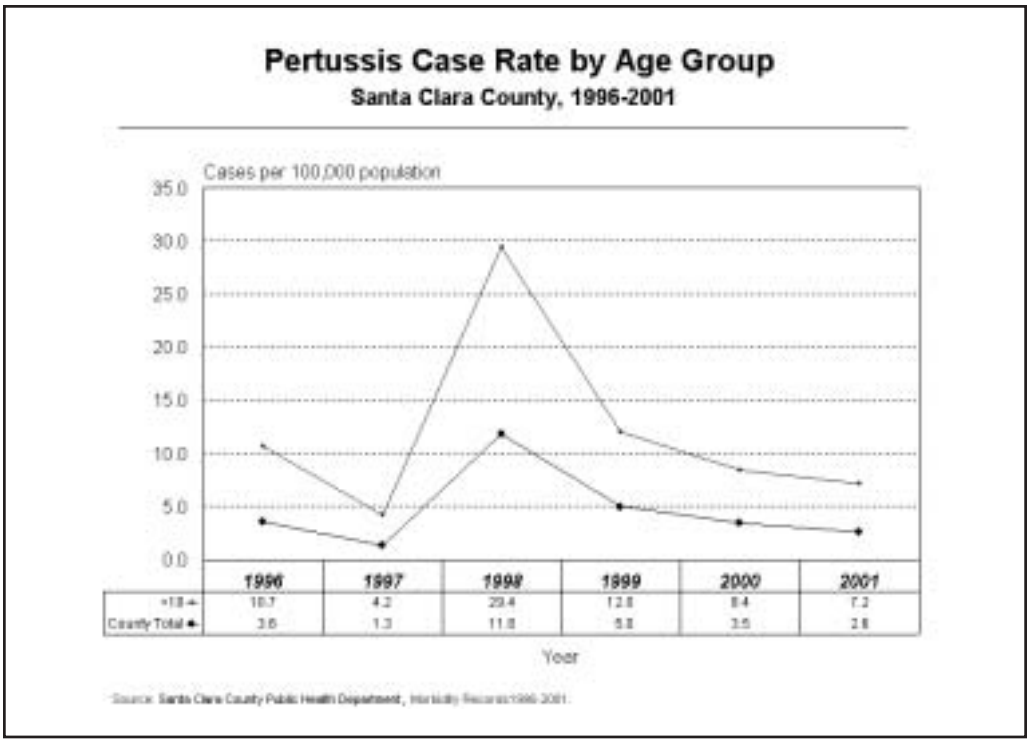


Figure 18

Vaccine Preventable Diseases among <18 years of age

Santa Clara County, 1996-2001

YEAR OF DIAGNOSIS	CONGENITAL RUBELLA SYNDROME	RUBELLA	DIPTHERIA	MEASLES	POLIO-MYELITIS	TETANUS
1996	0	1	0	0	0	0
1997	0	0	0	0	0	0
1998	1	0	0	0	0	0
1999	0	0	0	0	0	0
2000	0	0	0	0	0	0
2001	0	0	0	0	0	0

Source: Santa Clara County Public Health Department, Morbidity Records 1996-2001

Mortality & Morbidity

Monitoring childhood mortality rates (rates of death) and morbidity rates (rates of disease) assists in identifying the risks factors related to death and disease from specific causes. The rates also provide critical information for understanding preventable and premature illness and death in children, which may help health professionals design policies and programs that will reduce the rates of childhood deaths and disease in a community. Health indicators in this section are: leading causes of death, leading causes of hospitalization, leading causes of injury, and chronic conditions (cancer types, asthma, disabilities).

Leading Causes of Death

Almost twice as many children die during the first year of life as during the next 13 years total. These deaths are caused primarily by congenital anomalies, fetal growth retardation/immaturity, respiratory conditions, maternal complications, SIDS, and other causes. For children and teens, the leading causes of death have changed over the last several decades from natural causes, such as illness and birth defects, to injury and violence. The death rate rises rapidly following puberty because of the large numbers of unintentional injuries (such as automobile-related injuries), homicides and suicides in the 15 to 24-year-old age bracket. In fact, the majority of teen deaths can be attributed to preventable factors, including unhealthy behaviors such as sedentary life style, unsafe sexual practice, substance use and abuse, poor nutritional habits, and risky driving.[36]

Table 12
Death Rates by Age
(number of deaths per 100,000 in each age group)

	1-4 Years	5-9 Years	10-14 Years	15-17 Years*
Santa Clara County 2000**	19.3	15.2	12.3	23.9
California 2001***	23.9	12.4	15.1	NA
Healthy People 2010 Objective	25.0	14.3	16.8	NA

*Note. Age category is 15-19 years; thus, data from state and HP 2010 is not comparable for this age group.

**Santa Clara County Public Health Department, Birth & Death Records, 2000

***California Department of Health Services, Death Records, 2001

Leading Causes of Death continued

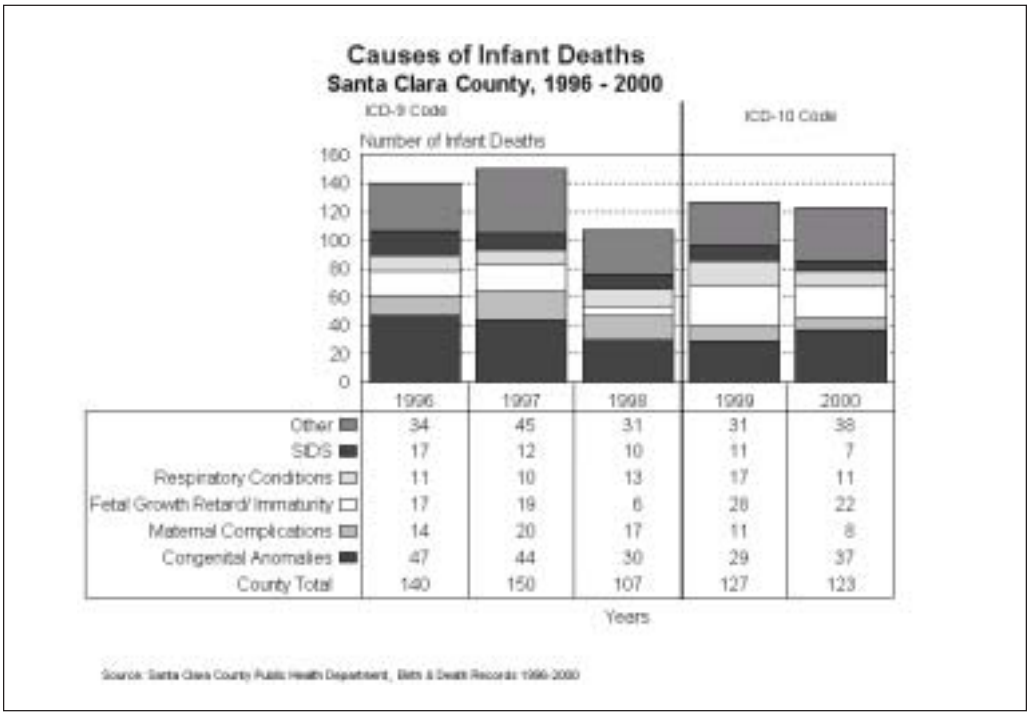
KEY FINDINGS

Among infants, the specific leading causes of death from 1996 to 2000 were congenital anomalies, fetal growth retardation/ immaturity, respiratory conditions, maternal complications, and SIDS (Figure 19).

Unintentional injuries and adverse effects were the leading causes of death for children age 1 to 4 years (Figure 20). Among children age 5 to 9 years, cancer was the leading cause of death, followed by motor vehicle traffic accidents. The leading cause of death for children age 10 to 14 was motor vehicle traffic accidents. Among 15 to 17-year-olds, suicide was the leading cause of death, followed by motor vehicle traffic accidents (Figure 20).

Overall, death rates for all children have declined from 1996 to 2000, except for children age 5 to 9 (Figure 21). In 2000, Santa Clara County has surpassed the Healthy People Year 2010 Objectives for age groups 1 to 4 years, 10 to 14 years, and 15 to 17 years.

Figure 19



Leading Causes of Death continued

Figure 20

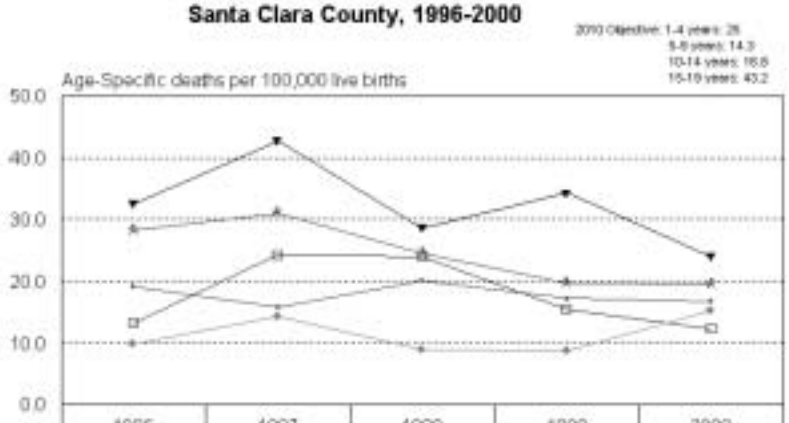
Leading Causes of Death Among Children 1-17 Years of Age
Santa Clara County, 2000

Cause of Death (n)	1-4	5-9	10-14	15-17	Total County Deaths
Motor Vehicle Traffic Accidents	1	3	4	3	124
Suicide	0	0	1	4	117
Homicide	0	1	0	1	42
Unintentional Injuries and Adverse Effects*	6	1	3	2	201
Diseases of the Heart	1	2	1	2	2550
Cancer (includes all cancers)	1	5	2	0	2082
Congenital Anomalies	3	2	0	1	63
Pneumonia and Influenza	1	1	1	1	356
Asthma	0	0	1	1	24

*w/o Motor Vehicle Traffic Accidents
Source: Santa Clara County Public Health Department, Birth & Death Records 1996-2000

Figure 21

Death Rates Among Children 1- 17 Years of Age
Santa Clara County, 1996-2000



	1996	1997	1998	1999	2000
County Total	19.0	15.8	20.0	17.2	16.8
1-4 Years	28.2	31.0	24.5	19.7	19.5
5-9 Years	9.8	14.3	9.0	8.8	15.2
10-14 Years	13.2	24.2	23.9	15.4	12.3
15-17 Years	32.4	42.7	28.7	34.3	23.9

Source: Santa Clara County Public Health Department, Birth & Death Records 1996-2000

Leading Causes of Hospitalization

BACKGROUND

Hospitalization indicates that the child was suffering from a severe form of a condition that required medical attention. Hospitalization rates are based on the number of discharges for ambulatory care sensitive conditions (ACS) from an overnight stay at a hospital.

KEY FINDINGS

The following data on the causes of hospitalization suggest that prevention services and health promotion activities could reduce the number of childhood hospitalizations in Santa Clara County.

Kidney/urinary infections, dehydration and pneumonia were the top three causes of hospitalization for children under one year of age (Figure 22). Dehydration, injuries, asthma, and pneumonia were the top four causes of hospitalization among children age 1 to 4. Injury was the leading cause of hospitalization for children in all other age groups (Figure 23).

Figure 22

Top Ten Leading Causes of Hospitalization from Injury and Ambulatory Care Sensitive Conditions
Santa Clara County, 2000

Under 1 year of age

Rank	Cause	Count
1	Kidney/Urinary Infection	124
2	Dehydration	121
3	Pneumonia	111
4	Asthma	71
5	Injuries	61
6	ENT conditions	48
7	Convulsion	28
8	Gastroenteritis	24
9	IZ Related Condition	14
10	Failure to Thrive	11

Source: Santa Clara County Public Health Department, Patient Discharge Data, 2000

Leading Causes of Hospitalization continued

Figure 23

Top Ten Leading Causes of Hospitalization from Injury and Ambulatory Care Sensitive Conditions Santa Clara County, 2000

Rank	Cause	1-4 years	Cause	5-9 years	Cause	10-14 years	Cause	15-19 years
1	Dehydration	319	Injuries	235	Injuries	296	Injuries	597
2	Injuries	276	Asthma	110	Asthma	63	Diabetes	46
3	Asthma	254	Dehydration	69	Diabetes	41	Kidney/Urinary Infection	31
4	Pneumonia	211	Pneumonia	69	Pneumonia	30	Asthma	30
5	Convulsion	103	Gastroenteritis	25	Dehydration	24	Pneumonia	28
6	Kidney/Urinary Infection	36	Convulsion	21	Kidney/Urinary Infection	17	Epileptic convulsion	21
7	Gastroenteritis	33	Diabetes	20	Gastroenteritis	15	Dehydration	19
8	Epileptic convulsion	29	Kidney/Urinary Infection	20	Convulsion	12	Convulsion	16
9	ENT conditions	15	Epileptic convulsion	14	Epileptic convulsion	6	ENT conditions	9
10	COPD	12	ENT conditions	8	ENT conditions	3	Gastroenteritis	9

Source: Santa Clara County Public Health Department, Patient Discharge Data, 2000

Leading Causes of Injury

BACKGROUND

The risk of everyday personal and unintentional injury is often high, yet the topic is not given the level of attention it deserves due to the erroneous belief that injuries happen by chance and result from unavoidable accidents. However, many injuries are not accidents; they are actually predictable and preventable.[36]

HOW ARE WE DOING?

Table 13
Rate of Hospitalizations Due to Unintentional Injuries per 100,000

Age:	<1 Year	1-4 Years	5-12 Years	13-15 Years	16-20 Years
Santa Clara County (2000)	14.7	24.7	16.0	19.7	30.9
California (2000)	25.1	29.7	20.4	30.7	38.3

Source: California Department of Health Services, 2000

KEY FINDINGS

Common causes of injuries in Santa Clara County are traffic-related collisions, blunt assaults, gunshot wounds, falls, and stabbings. In 2000, a total of 872 children and adolescents were admitted to the trauma care system for injuries, 13 of which resulted in deaths (Table 14). Approximately 68% of these injuries and 69% of deaths were due to traffic-related collisions. In 2001, a total of 855 children and adolescents were admitted to the trauma care system for injuries, eight of whom died. Approxi–mately 67% of these injuries and 75% of these deaths were due to traffic-related collisions.[46]

Leading Causes of Injury continued

Table 14
Causes of Injuries and Deaths Among Patients Admitted to the Santa Clara County Trauma System

	0-5 Years		6-11 Years		12-17 Years		Total	
Cause of Injury	2000	2001	2000	2001	2000	2001	2000	2001
Traffic								
Injuries	153	138	159	124	283	312	595	574
Death	6	1	2	2	1	3	9	6
Blunt Assault								
Injuries	3	1	3	0	18	26	24	27
Death	0	1	0	0	0	0	0	1
Gunshot Wounds								
Injuries	0	1	0	0	3	12	3	13
Death	0	0	0	0	1	1	1	1
Stabbing								
Injuries	3	0	0	0	23	15	26	15
Death	0	0	0	0	2	0	2	0
Falls								
Injuries	75	84	49	41	44	28	168	153
Death	1	1	0	0	0	0	1	1
Other								
Injuries	12	18	11	20	33	35	56	73
Death	0	0	0	0	0	1	0	1
TOTAL								
Injuries	246	242	222	185	404	428	872	855
Death	7	3	2	3	4	2	13	8

Source: Santa Clara County EMS Agency, 2002

Chronic Conditions: Cancer

BACKGROUND

Cancer occurs when abnormal cells divide without control. These "cancer cells" can invade nearby tissue and spread through the bloodstream and lymphatic system to other parts of the body.[47] Cancer is the leading cause of death by disease among U.S. children under age 15, despite being relatively rare in this age group. The causes of childhood cancers are largely unknown, although environmental causes have long been suspected. Of the 12 major types of childhood cancers, leukemias (blood cell cancers) and brain and other central nervous system tumors account for over one-half of the new cases.[48]

HOW ARE WE DOING?

Table 15
Age-Specific Cancer Incidence Rates Per 100,000

	0-4 years	5-9 years	10-14 years
Santa Clara County (1992-1999 average)*	19.5	10.2	11.8
California (1995-1999 average)**	19.0	11.0	12.0

* Santa Clara County Public Health Department, Surveillance Epidemiology End Results, 1992-1999

** California Department of Health Services, 2001

KEY FINDINGS

The incidence of childhood cancers has declined in Santa Clara County in recent years (Figure 24). The average annual incidence rate for 1992 and 1993 was 21.5 for children age 0 to 19; by 1998-1999 the average annual rate decreased to 14.9 cases per 100,000 children. From 1992 through 1999, there were a total of 652 cases of childhood cancers. For all races/ethnicities, the rate of childhood cancers either decreased or remained the same from 1992 to 1999. The greatest decrease occurred among Whites and unknown races. Some of this change is attributed to better classification of race/ethnicity for cancer cases.

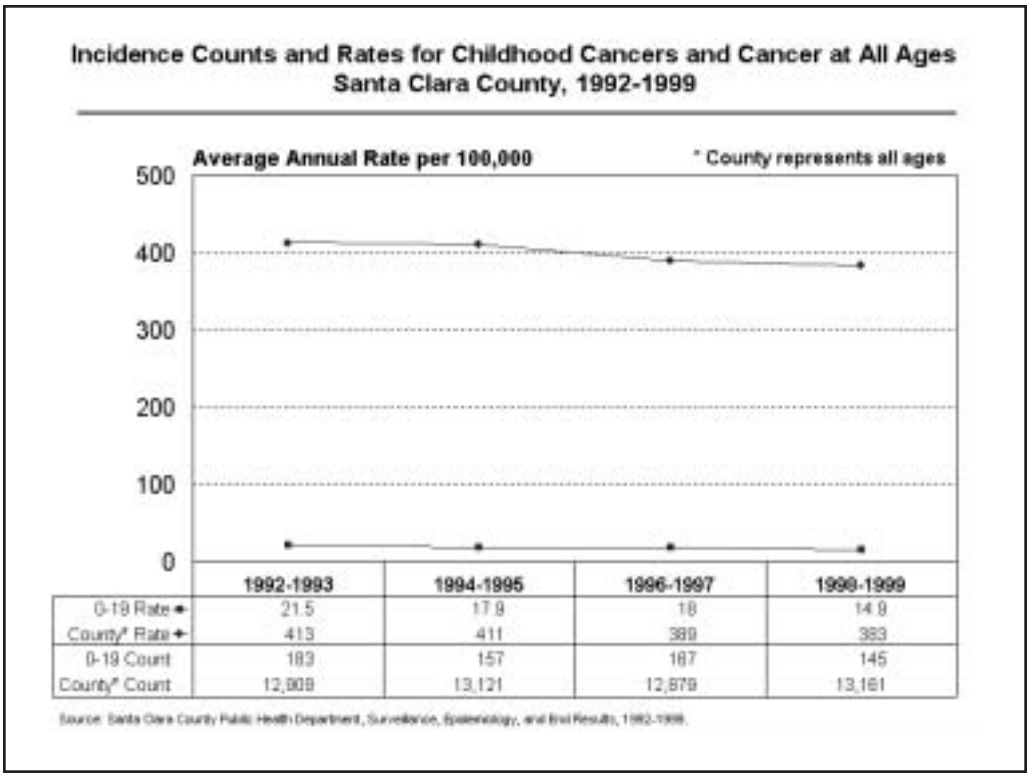
Childhood cancer rates for both males and females went down from 1992-1999 (Figure 25). Age-specific cancer rates were lowest for children age 5-9 years and 10-14 years. Cancer rates are at their highest for those age 20 years and over (Figure 26).

The primary cancer types were leukemia, lymphomas, brain/central nervous system (CNS), and carcinomas (Figure 27). The rate of leukemia is slightly higher in males than females. Carcinomas comprised the majority of cancer incidence in females.

Survival time of cancer patients after diagnosis is an indicator of access to early intervention and treatment effectiveness. Of all children diagnosed with cancers from 1992-1994, 67% survived after five years; 75% of those diagnosed with cancers from 1992-1996 survived after three years; and, 88% of those diagnosed with cancers from 1992-1998 survived after one year (Figure 28). Death counts only include those who died from cancer; it excludes those diagnosed with cancers who may have died from causes other than cancer.

Chronic Conditions: Cancer continued

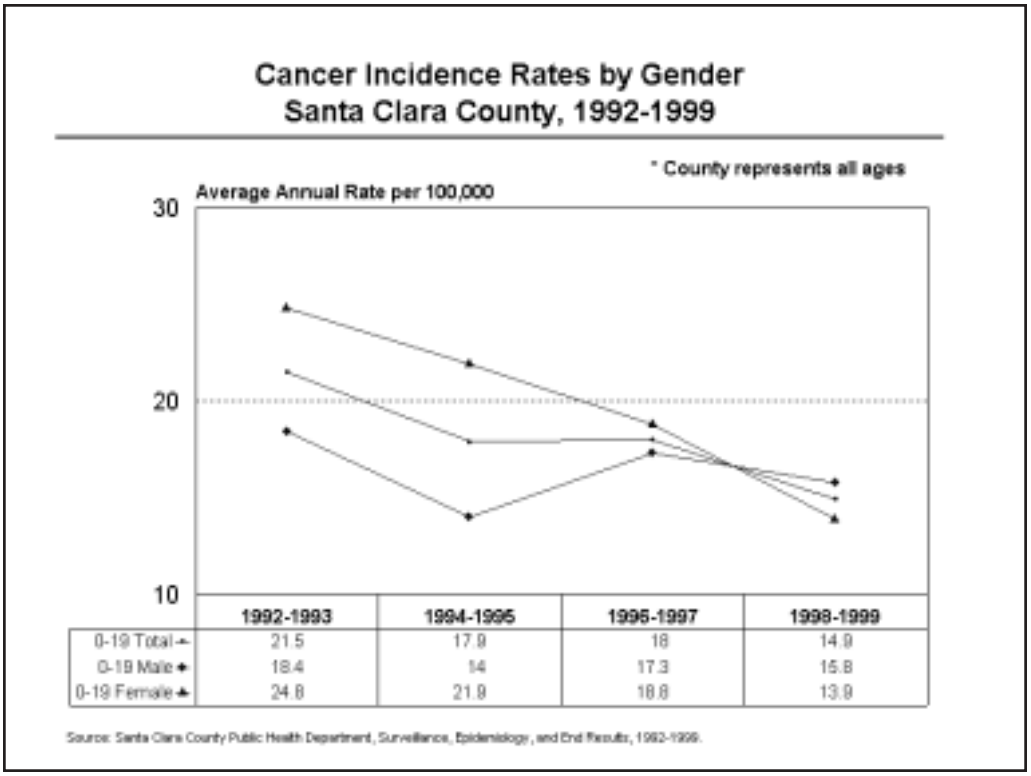
Figure 24



	1992-1993	1994-1995	1996-1997	1998-1999
0-19 Rate	21.5	17.9	18	14.9
County* Rate	413	411	389	383
0-19 Count	183	157	167	145
County* Count	12,909	13,121	12,879	13,161

Source: Santa Clara County Public Health Department, Surveillance, Epidemiology, and End Results, 1992-1999.

Figure 25



	1992-1993	1994-1995	1995-1997	1998-1999
0-19 Total	21.5	17.9	18	14.9
0-19 Male	18.4	14	17.3	15.8
0-19 Female	24.8	21.9	18.8	13.9

Source: Santa Clara County Public Health Department, Surveillance, Epidemiology, and End Results, 1992-1999.

Chronic Conditions: Cancer continued

Figure 26

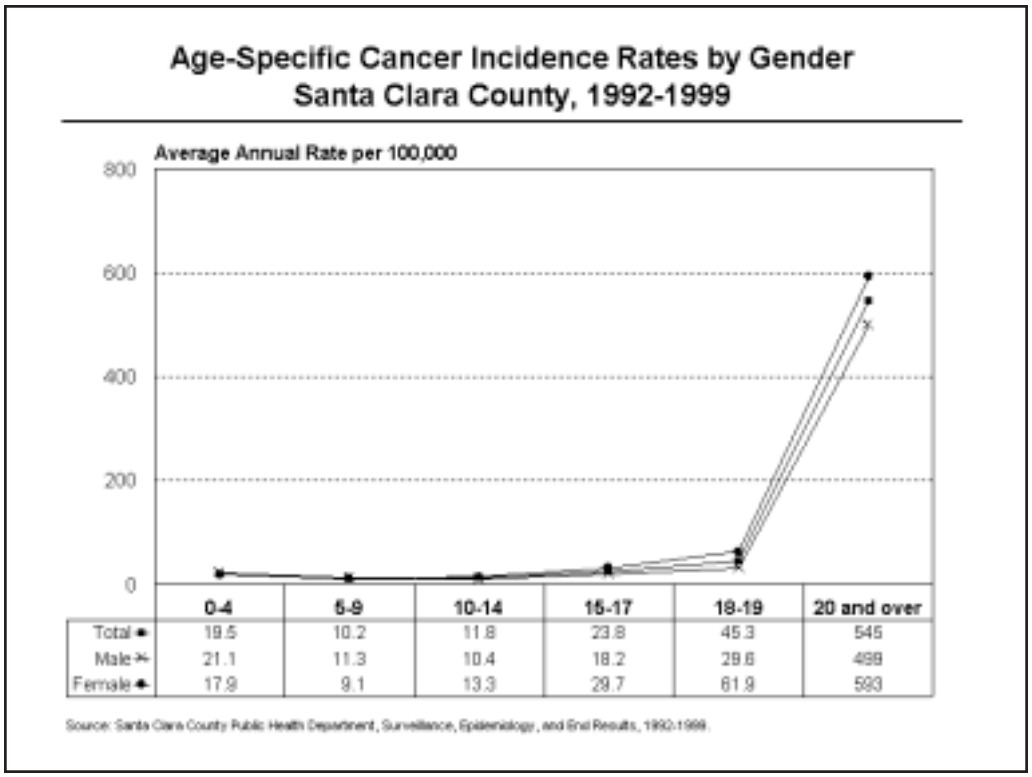
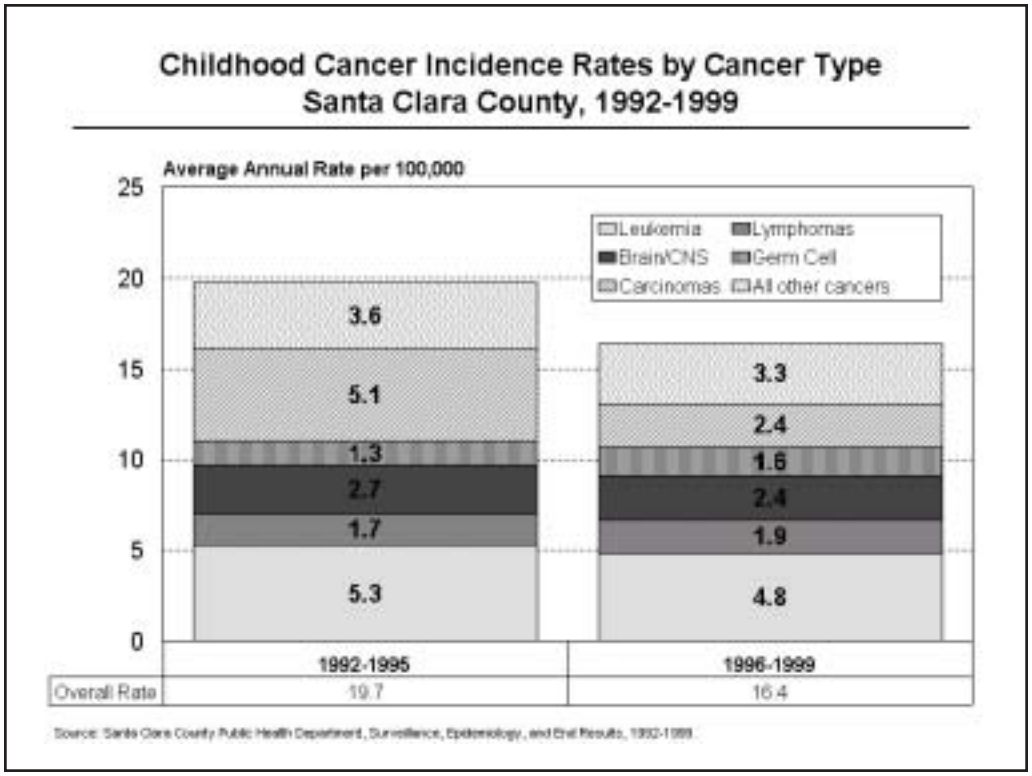
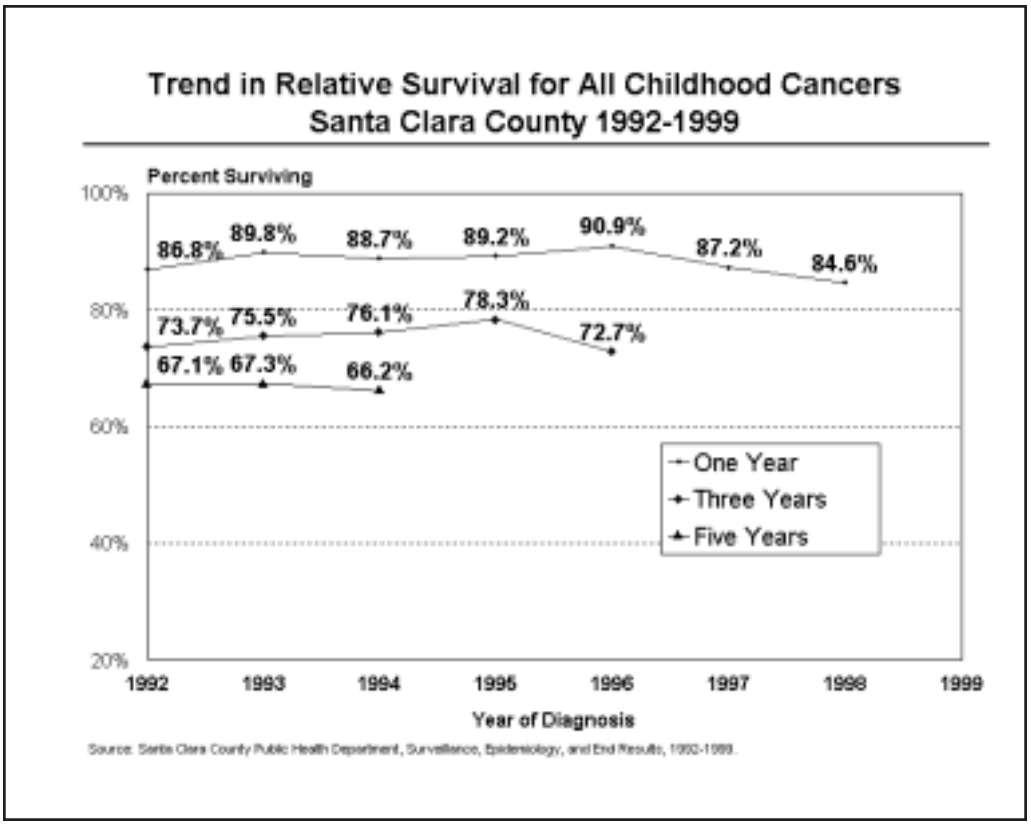


Figure 27



Chronic Conditions: Cancer continued

Figure 28



Chronic Conditions: Asthma

BACKGROUND

Asthma is a chronic inflammatory lung disease that causes airways to tighten and narrow making breathing difficult. Symptoms are wheezing, shortness of breath, coughing, and chest tightness. Asthma can be controlled by taking medication and by avoiding contact with environmental "triggers" such as cockroaches, dust mites, furry pets, mold, tobacco smoke, and certain chemicals.

Asthma is a major public health problem in the United States. It affects nearly five million people under age 18 and is the third-ranking cause of hospitalization among those under age 15. The number of children dying from asthma increased almost three-fold from 1979 (93 deaths) to 1996 (266 deaths) in the nation. Low-income populations, minorities, and children living in inner cities experience disproportionately higher morbidity and mortality due to asthma. The estimated cost of treating asthma in those younger than 18 years of age is $3.2 billion per year.[49]

HOW ARE WE DOING?

Table16
Asthma Hospitalization Rates in Children 0-5 years old per 10,000

Santa Clara County	24.2
California	31.7
Healthy People 2010 Objective	25.0

Source: California Department of Health Services, Environmental Health Investigations Branch, 2000

KEY FINDINGS

Santa Clara County has met the Healthy People 2010 Objective for asthma hospitalizations for children under 5 years of age.

A total of 498 Santa Clara County children age 0-14 years were hospitalized in 2000 due to asthma, for a rate of 126 per 100,000 children age 0-14 years (Figure 29). The rate of asthma hospitalizations remained fairly constant from 1998 to 2000.

The 2000 age-specific asthma hospitalization rate was highest for those under five years of age (Figure 30).

The asthma hospitalization rate ratio of males to females under age 15 years was 1.75 in 1998. The rate ratio increased only slightly to 1.91 in 2000. For the overall county population, the rate ratio is reversed – the asthma hospitalization rate is higher in females than males (Figures 31, 32).

Overall, about 18% of Santa Clara County children surveyed reported being told by a physician that they have asthma (Figure 33). More Native American and African-American students reported having asthma than Whites, Hispanics, and Asians/PIs.

Approximately 9% of students reported that they had visited a doctor during the past year for wheezing (Figure 34). Although more boys were diagnosed with asthma than girls, more girls had visited a doctor or hospital for symptoms of wheezing during last one year than boys.

Chronic Conditions: Asthma continued

Figure 29

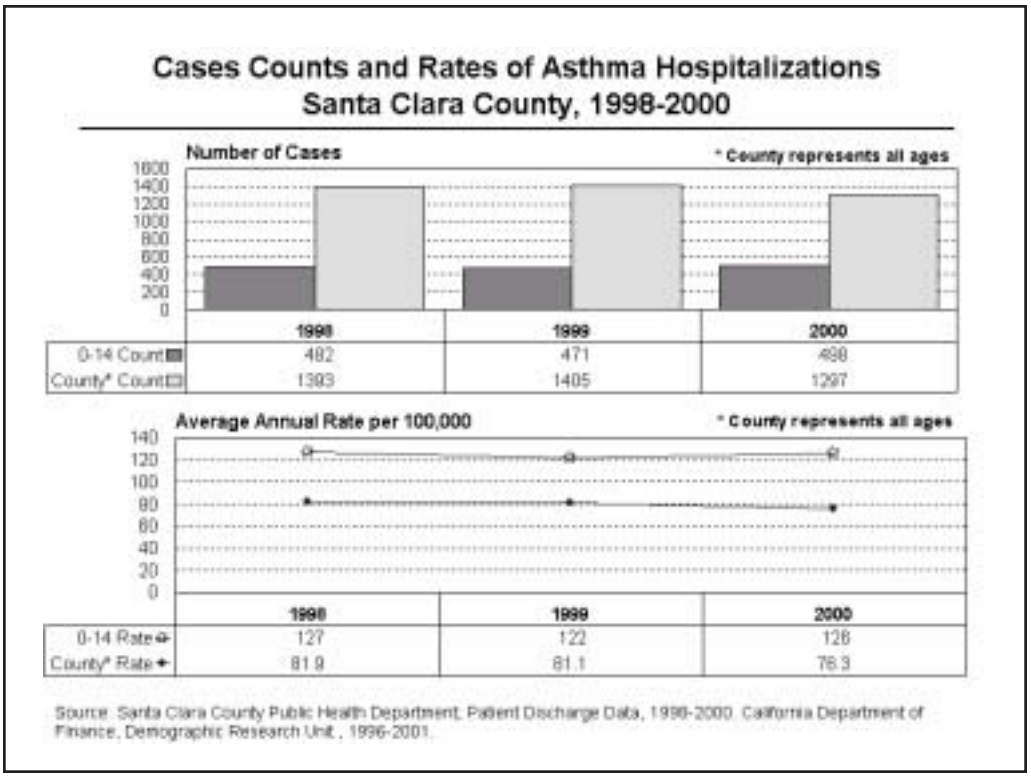
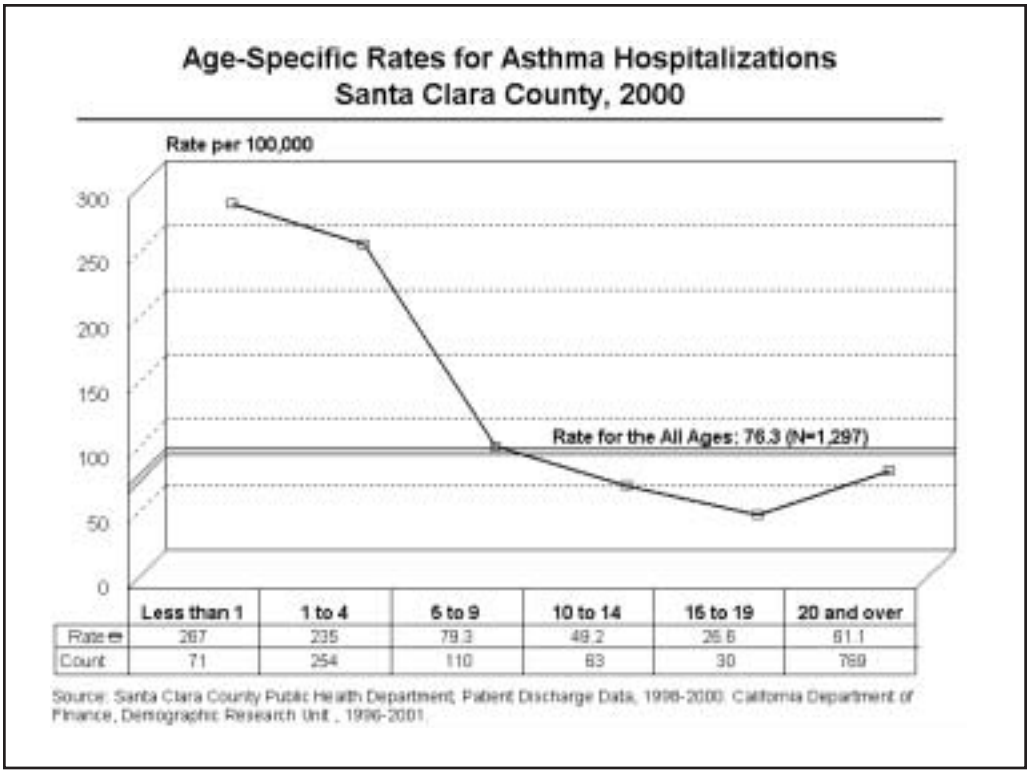


Figure 30



Chronic Conditions: Asthma continued

Figure 31

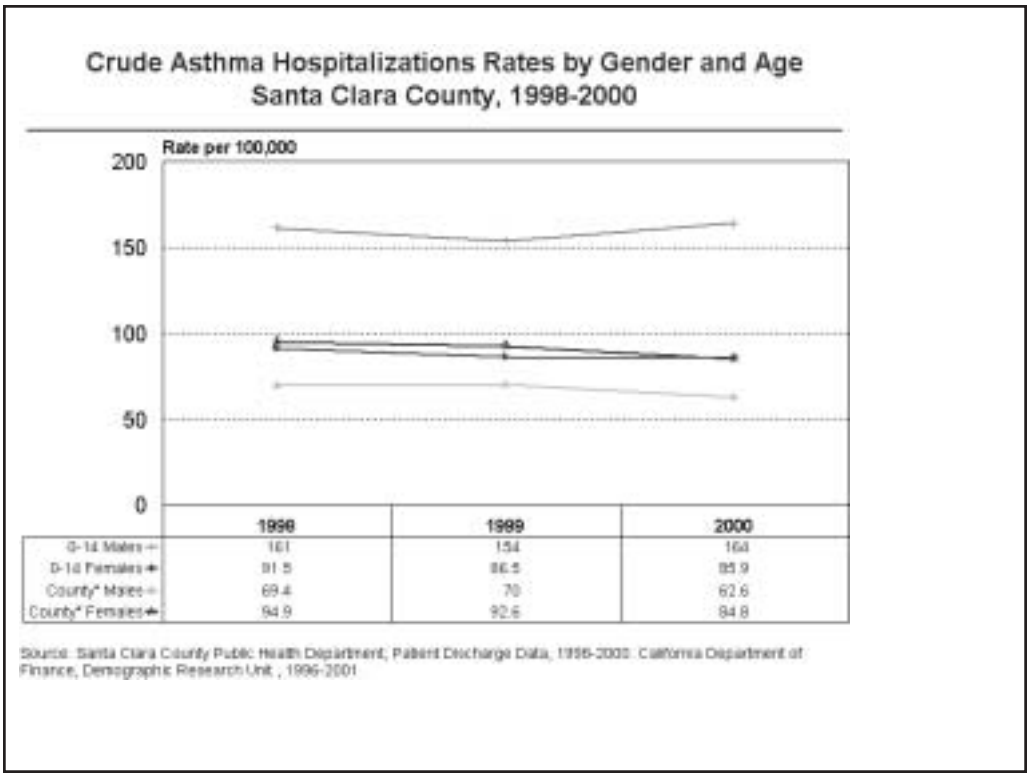
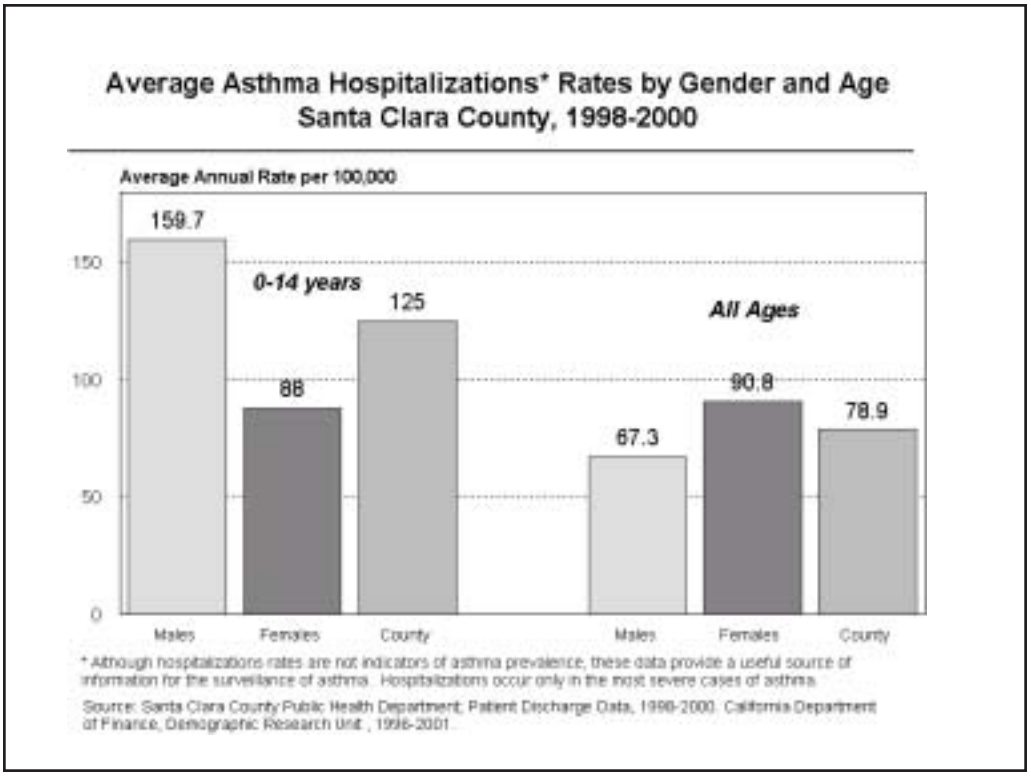


Figure 32



Chronic Conditions: Asthma continued

Figure 33

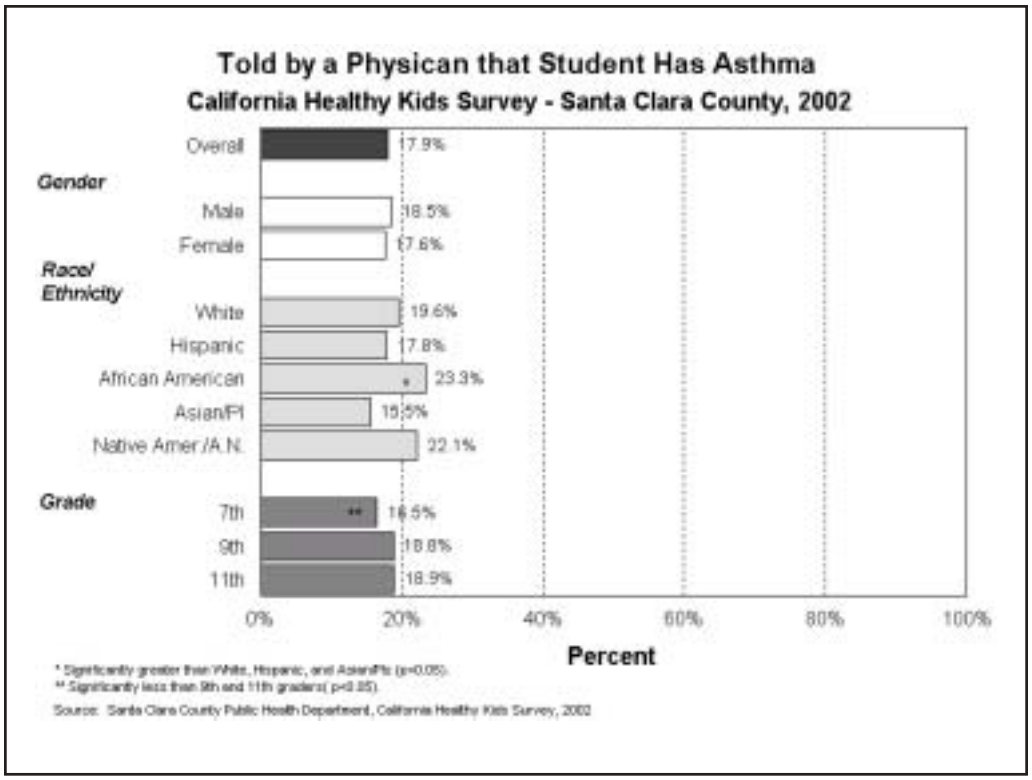
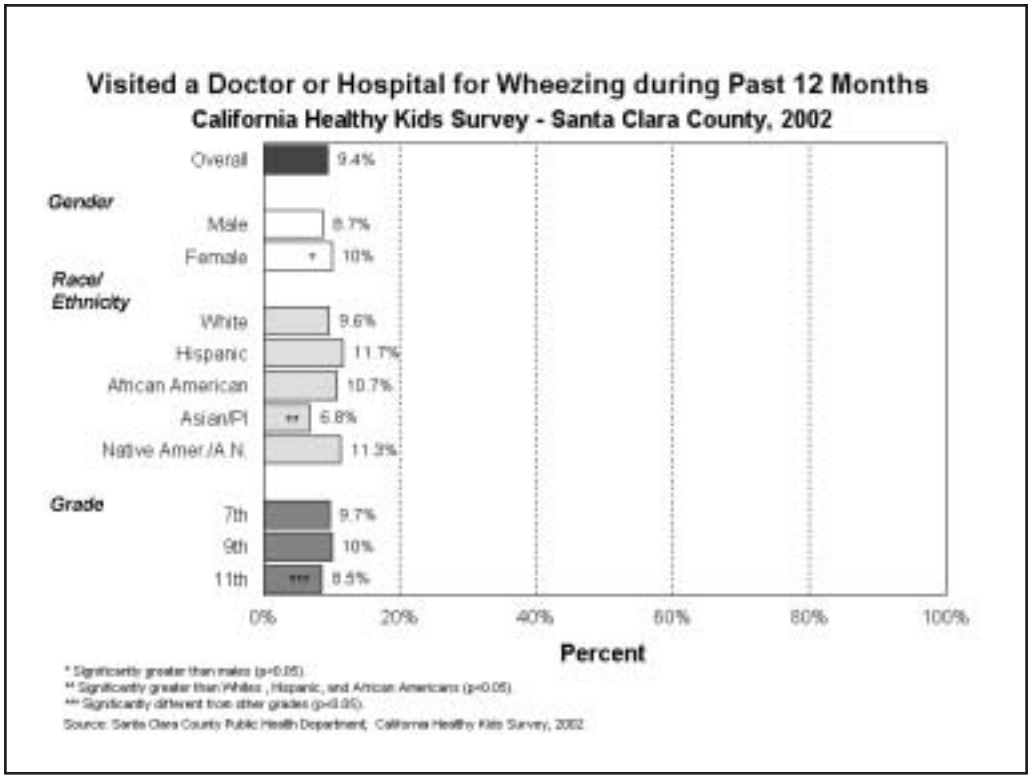


Figure 34



Communicable Diseases

Communicable diseases are preventable by vaccination, responsible behaviors, and health education. However, with the emergence of drug resistant strains of tuberculosis and various food and water borne organisms, the control of communicable diseases continues to affect individual and community health. Infectious diseases, are a significant cause of illness, disability, and death. Other factors such as travel, food imports, changes in the environment, and inappropriate use of antibiotics on humans and animals have contributed to the complexity of the problem. Leading indicators for communicable diseases include the top 10 communicable diseases among children in Santa Clara County, along with sexually transmitted diseases (STDs), HIV/AIDS, Tuberculosis, and Perinatal Hepatitis B.

Leading Communicable Diseases

BACKGROUND

In Santa Clara County, the leading commu–nicable diseases are caused by unsafe sexual practices, inadequate or improper hygiene, and lack of vaccination. Some leading causes of communicable diseases include sexually transmitted diseases such as chlamydia and gonorrhea; food and water borne diseases such as Salmonella, Shigella, Campylobacter, Giardia, and Hepatitis A; and some vaccine preventable diseases such as Hepatitis B and Pertussis (Figure 35).

HOW ARE WE DOING?

Table 17
Communicable Diseases
Rate per 100,000 population

	Hepatitis	Shigellosis
Santa Clara County*	8.1	8.5
California**	15.1	8.1
Healthy People 2010 Objective	NA	NA

*Santa Clara County Public Health Department, Confidential Morbidity Report, 2001

**Source: California Department of Health Services, 2002

KEY FINDINGS

The leading causes of reportable morbidity from communicable diseases for children and youth include sexually transmitted diseases, food and water borne diseases, and vaccine preventable diseases (Figure 35). Chlamydia, followed by Giardia, Salmonella, and Campylobacter, accounted for the majority of illnesses in children and youth from 1996 to 2001 (Figure 36).

Leading Communicable Diseases continued

Figure 35

Leading Causes of Morbidity (< 18 years)

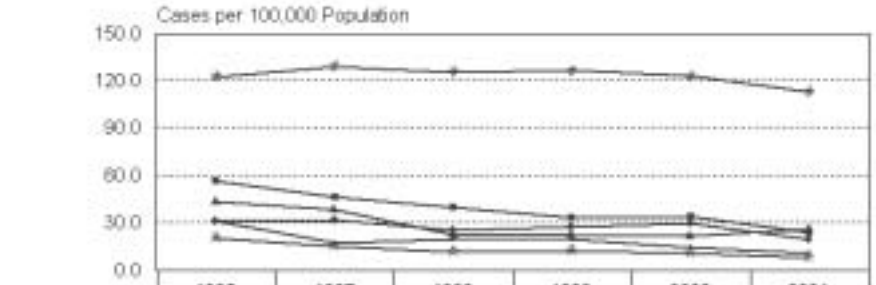
Morbidity	1996	1997	1998	1999	2000	2001
Chlamydia	513	557	554	570	566	530
Salmonella	183	164	99	102	99	121
Giardia	237	201	177	151	156	112
Campylobacter	130	136	111	124	136	93
Hepatitis B	129	75	85	87	66	51
Viral Meningitis	28	102	43	18	16	43
Gonorrhea	86	66	49	55	49	37
Pertussis	45	18	130	54	39	34
Shilgella	83	87	103	94	57	45
MRSA	24	16	6	25	18	21
Hepatitis A	36	91	29	43	38	17

Source: Santa Clara County Public Health Department, Morbidity Records 1996-2001

Figure 36

Causes of morbidity among children and youth (<18 yrs)

Santa Clara County, 1996-2001



	1996	1997	1998	1999	2000	2001
Chlamydia	122.1	128.9	125.3	126.2	122.6	112.7
Salmonella	43.6	38.0	22.4	22.6	21.4	25.7
Giardia	56.4	46.5	40.0	33.4	33.8	23.8
Campylobacter	30.9	31.5	25.1	27.5	29.5	19.8
Hepatitis B	30.7	17.4	19.2	19.3	14.3	10.8
GC	20.5	15.3	11.3	12.2	10.6	7.9

Diagnosis Year

Source: Santa Clara County Public Health Department, Morbidity Records 1996-2001

STDs: Chlamydia & Gonorrhea

BACKGROUND

Compared to older age groups, adolescents (10-19 years old) and young adults (20-24 years old) are at higher risk for acquiring sexually transmitted diseases (STDs) for a number of reasons: they may be more likely to have multiple (sequential or concurrent) sexual partners; they may be more likely to engage in unprotected intercourse; and they may select partners at higher risk. For some STDs, such as Chlamydia trachomatis, adolescent women may have a physiologically increased susceptibility to infection due to increased cervical ectopy. In addition, the higher prevalence of STDs among adolescents may reflect multiple barriers to quality STD prevention services, including lack of insurance or other ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality.[36]

HOW ARE WE DOING?

Table 18
Sexually Transmitted Diseases
Rates per 100,000 population

	Rate of Gonorrhea	Rate of Chlamydia
Santa Clara County 2001*	29.6	205.6
Santa Clara County 15-17 year olds 2001*	47.9	703.0
California 1998-2000 average	58.5	251.3
Healthy People 2010 Objective	19.0	NA

*Santa Clara County Public Health Department, Morbidity Records, 2001

**Source: Health Data Summaries for California, California Department of Health Services, 2002

KEY FINDINGS

The overall county rate of chlamydia infection has increased in both men and women since 1996 (Figure 37). In 2001, as in previous years (data not shown), males and females between ages 15-17 and 18-19 years experience the highest chlamydia rates in the county (Figure 38).

There has been a dramatic reduction of gonorrhea in females between the age of 10-14 and 15-17 years (Figure 39). However, gonorrhea rates among females between ages 15-17 and 18-19 are high as compared to the overall county rates (Figure 40).

STDs: Chlamydia & Gonorrhea continued

Figure 37

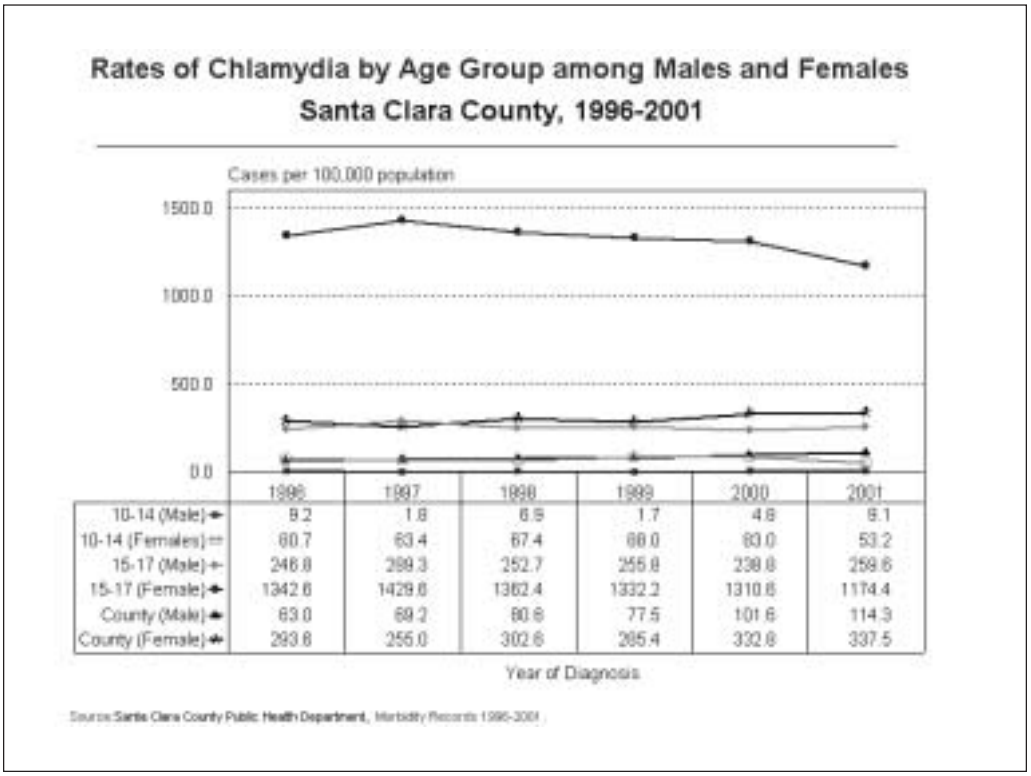
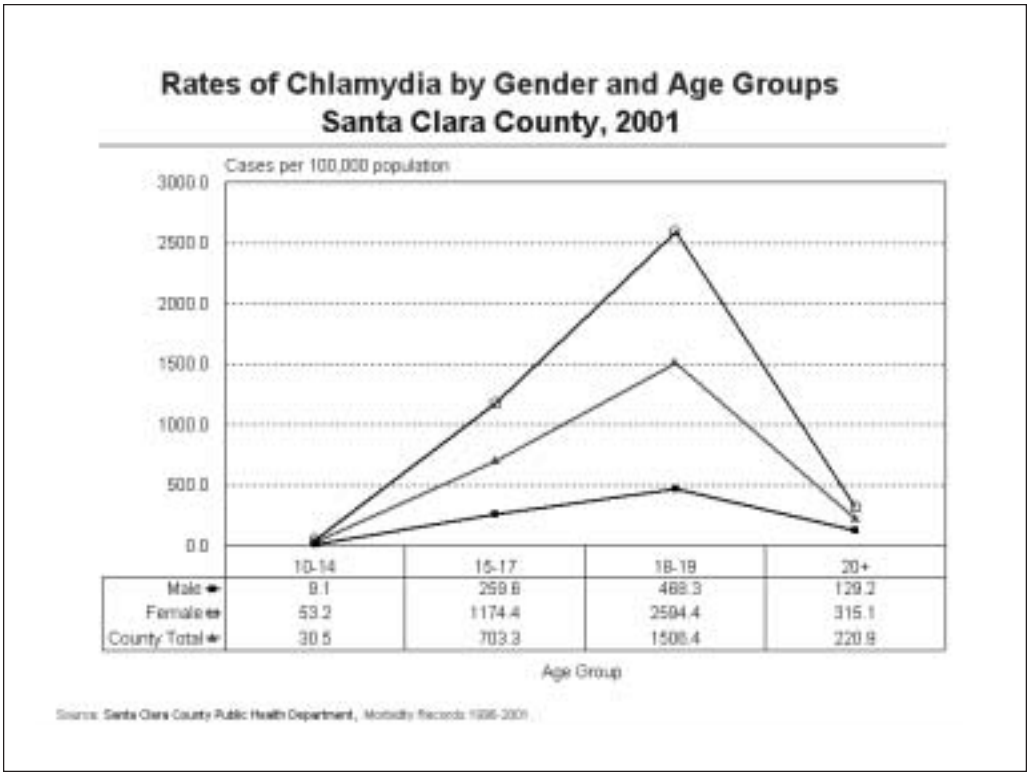
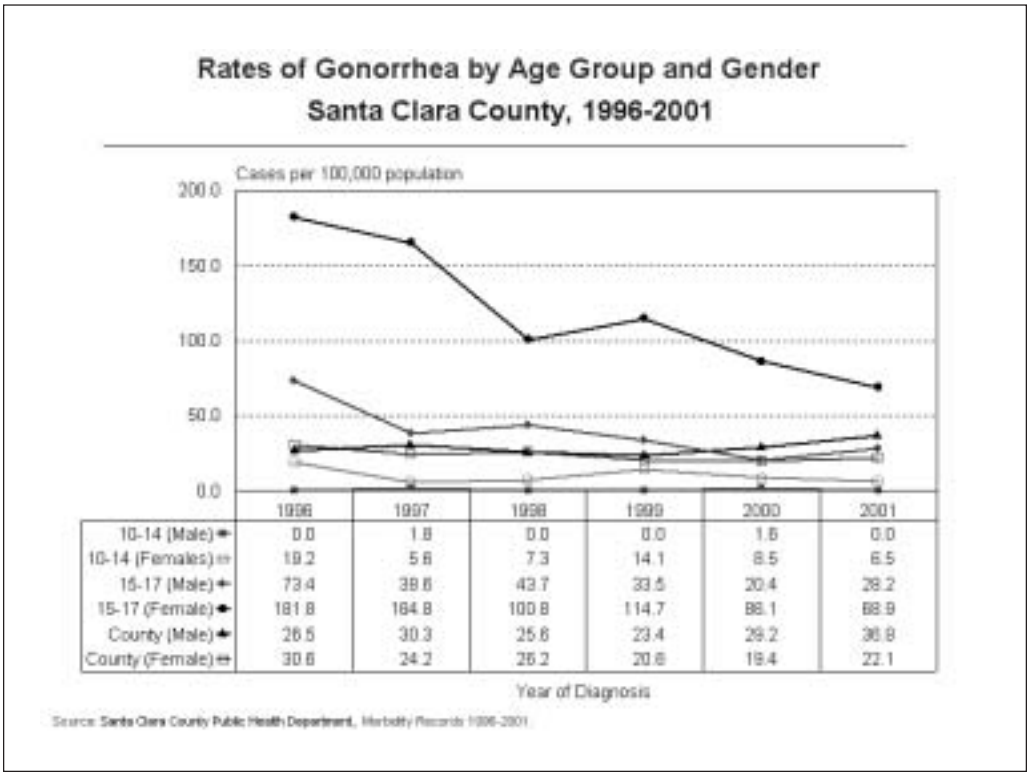


Figure 38



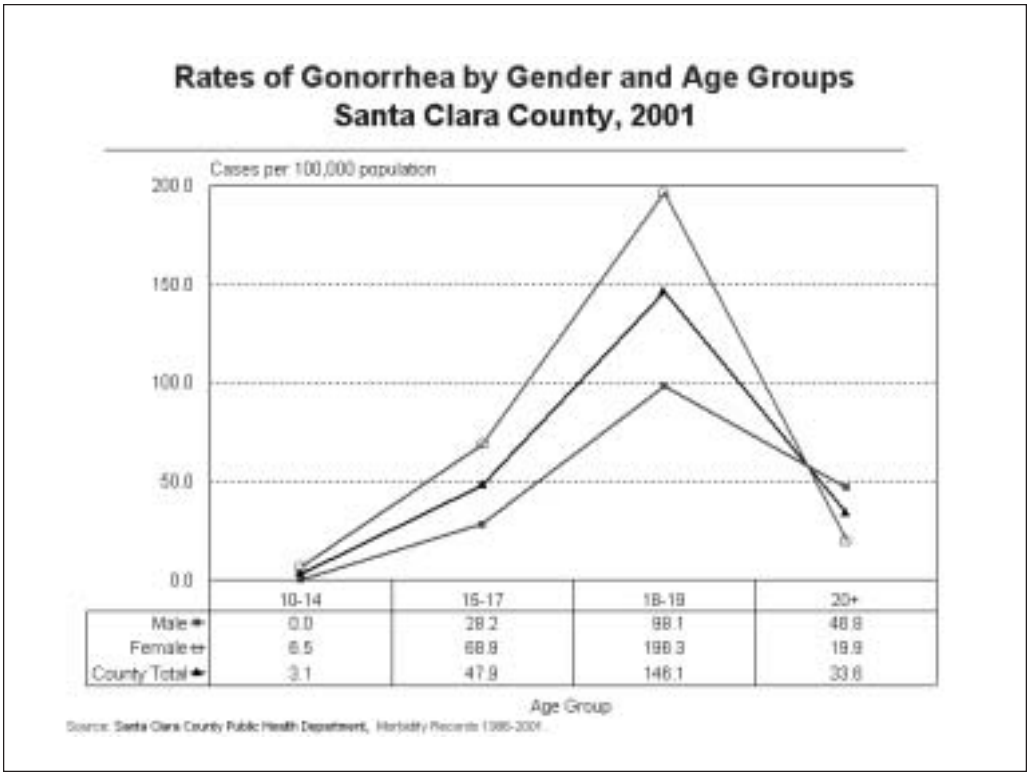
STDs: Chlamydia & Gonorrhea continued

Figure 39



	1996	1997	1998	1999	2000	2001
10-14 (Male)	0.0	1.8	0.0	0.0	1.6	0.0
10-14 (Females)	19.2	5.6	7.3	14.1	8.5	6.5
15-17 (Male)	73.4	38.6	43.7	33.5	20.4	28.2
15-17 (Female)	181.8	164.8	100.8	114.7	86.1	68.9
County (Male)	26.5	30.3	25.6	23.4	29.2	36.8
County (Female)	30.6	24.2	26.2	20.6	19.4	22.1

Figure 40



	10-14	15-17	18-19	20+
Male	0.0	28.2	98.1	48.8
Female	6.5	68.9	196.3	19.9
County Total	3.1	47.9	146.1	33.6

HIV / AIDS

HIV (human immunodeficiency virus), the virus that causes AIDS (acquired immunodeficiency syndrome), infects and takes over certain cells of the immune system that are important in fighting disease. Transmission of HIV can occur in three ways: sexual transmission, exchange of bodily fluids or blood products (i.e. needle sharing or blood transfusion), or from mother to baby during pregnancy or birth. Interventions to prevent HIV infection focus on promoting HIV testing; providing messages against needle sharing; and educating the public on safer sexual behavior, such as using condoms consistently and correctly, use of intravaginal microbicides, reducing the number of sex partners, and knowing the serostatus of one's partner. Moreover, detection and treatment of other STDs is also important because STDs are known to biologically enhance the transmission of HIV during sexual contact for both men and women. Depending on the co-infection of the STD involved, HIV transmission can be increased in a range from threefold to fifty-fold. Therefore, HIV/AIDS prevention and intervention programs should include both behavioral and biomedical strategies.[36]

HIV infection became reportable in the State of California in July 2002. Therefore, a thorough understanding of the prevalence of this infection in Santa Clara County does not yet exist. Also, data on AIDS is gathered at the time of an AIDS diagnosis and not at the time of acquiring an HIV infection. The time to develop an AIDS defining illness can be up to 10 years.

Table 19
Percent of Students who Receive HIV / AIDS Education in the Schools

	Middle School	High School
Santa Clara County 2001	64	NA
California	NA	NA
Healthy People 2010 Objective	95	95

Source: Santa Clara County Public Health Department, California Healthy Kids Survey (CHKS), 2002

HIV / AIDS continued

KEY FINDINGS

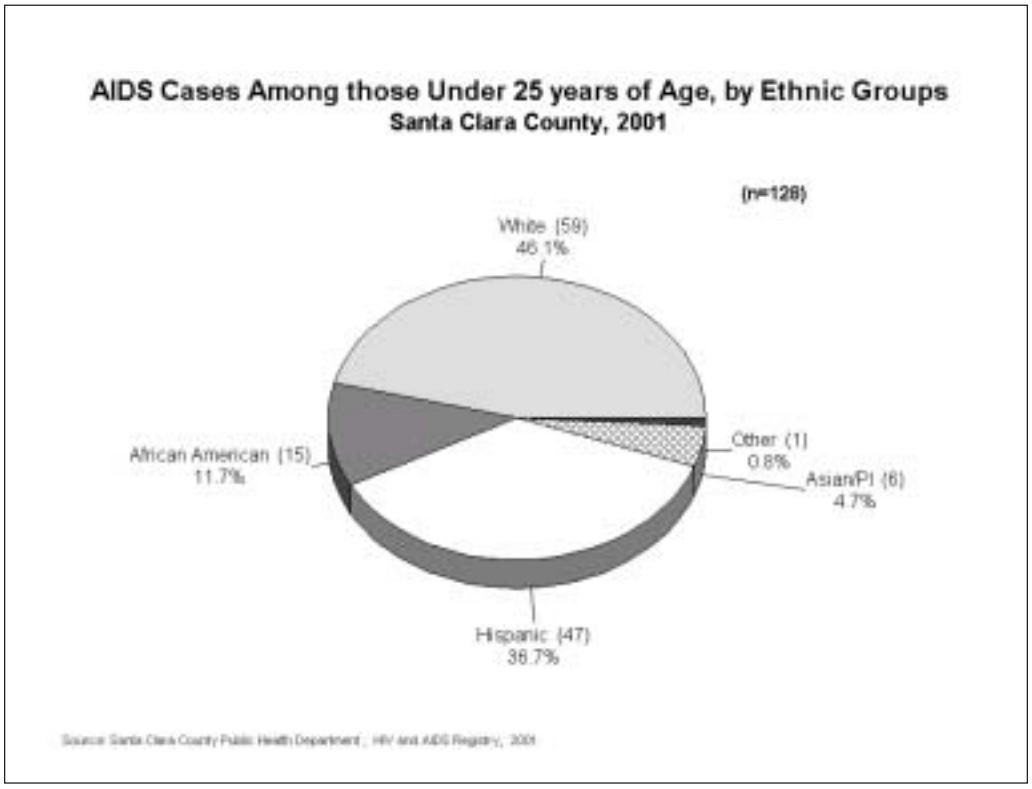
Between 1983 and 2001, there was a cumulative total of 3,263 AIDS cases reported in the county.[50] Of these, 128 cases were under the age of 25 (4% of the total). The majority of these cases were White or Hispanic (Figure 41), diagnosed between 19 and 24 years of age (Figure 42), and male (Figure 43). Men who have sex with men (MSM) accounted for over half (58%) of the AIDS cases diagnosed before the age of 25 (Figure 44). Hemophiliac/blood products and vertical transmission (mother to baby at pregnancy or birth) accounted for 10% and 11% respectively of the cases diagnosed before age 25 (Figure 43, 44).

AIDS cases among those under 25 years of age were compared between two 5-year intervals, 1990-1995 and 1996-2001, since there have been vast changes over the last decade in prevention efforts and therapies (Figure 45). The proportion of Whites among new cases declined significantly from 56% to 7%. However, the proportion of Hispanics doubled from 29% to 63%. Also, the proportion of men who have sex with men (MSM) increased.

Middle school students were asked in the California Healthy Kids Survey whether they received HIV/AIDS education at school (Figure 46). Approximately 64% reported receiving HIV education at school. The proportion of students who reported not receiving HIV/AIDS education at school was significantly higher among Hispanics than other groups. The response did not differ between males and females.

Please refer to the Behavioral Health section for additional information on teenage sexual behavior.

Figure 41



HIV / AIDS continued

Figure 42

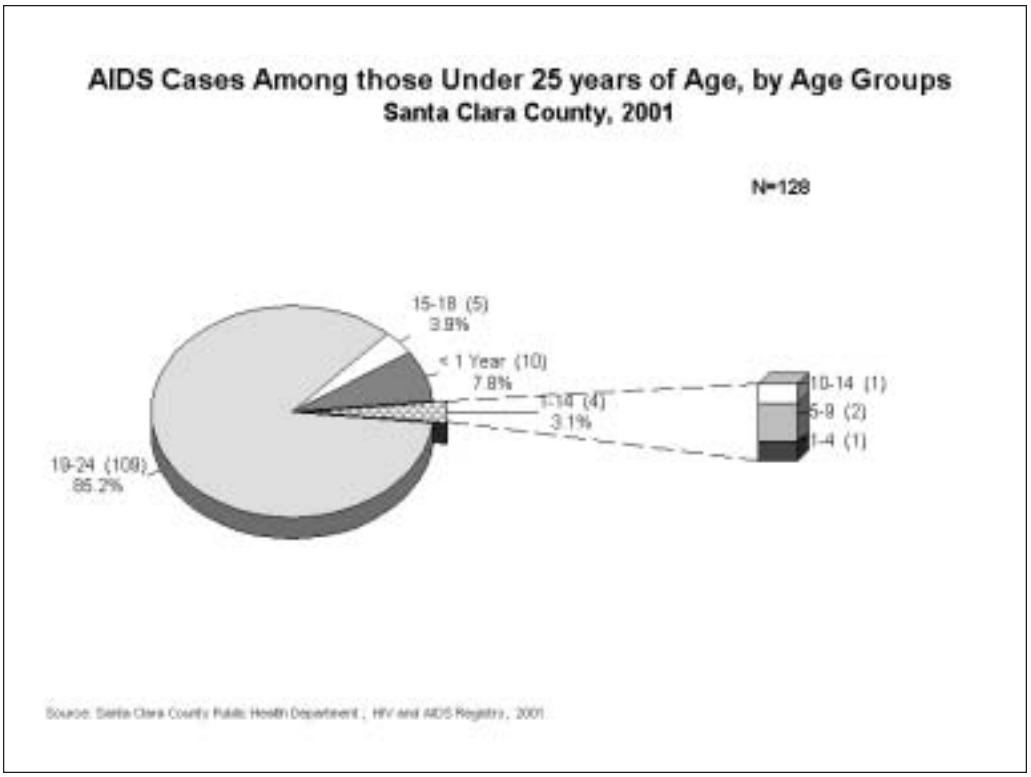
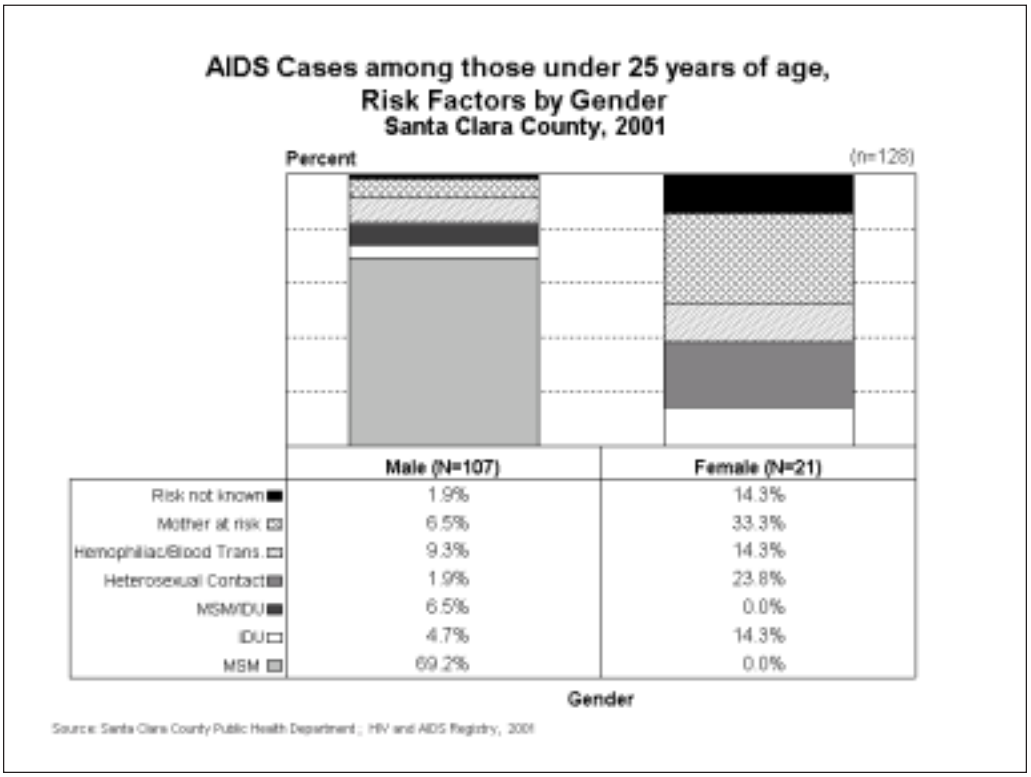


Figure 43



HIV / AIDS continued

Figure 44

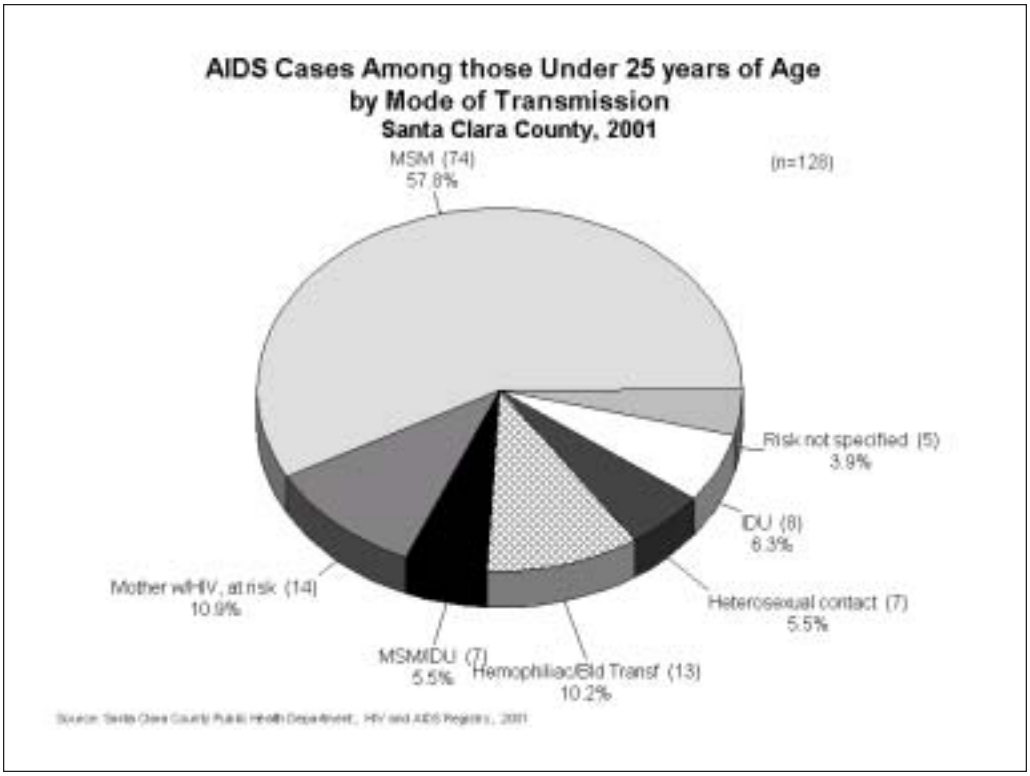
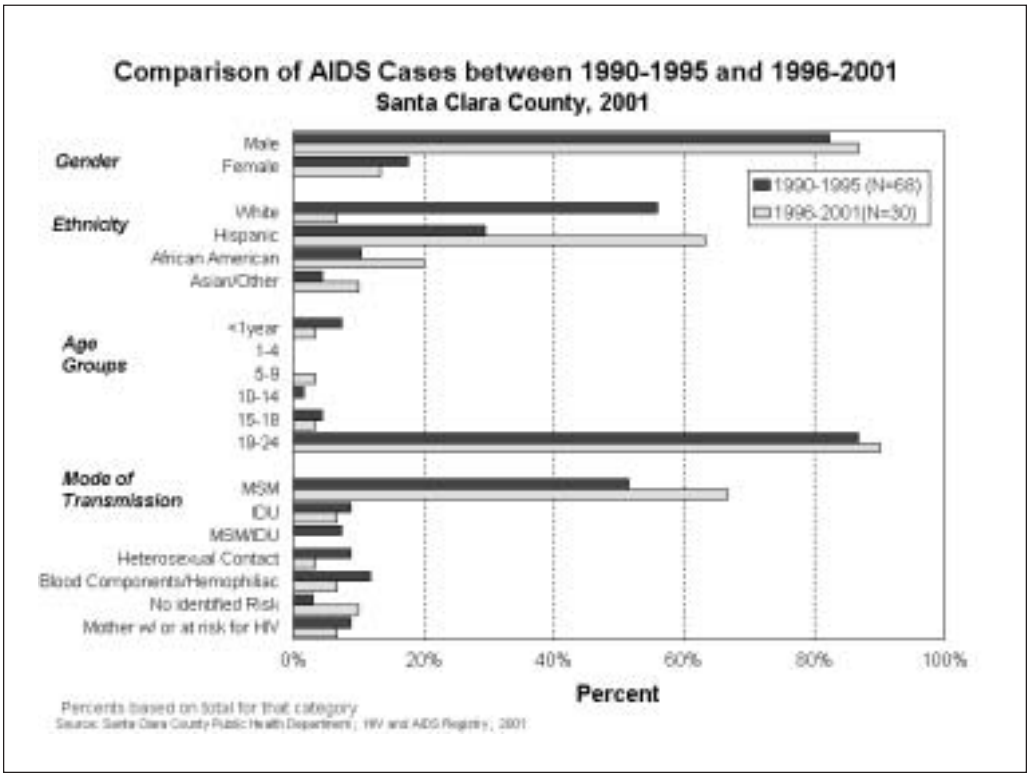
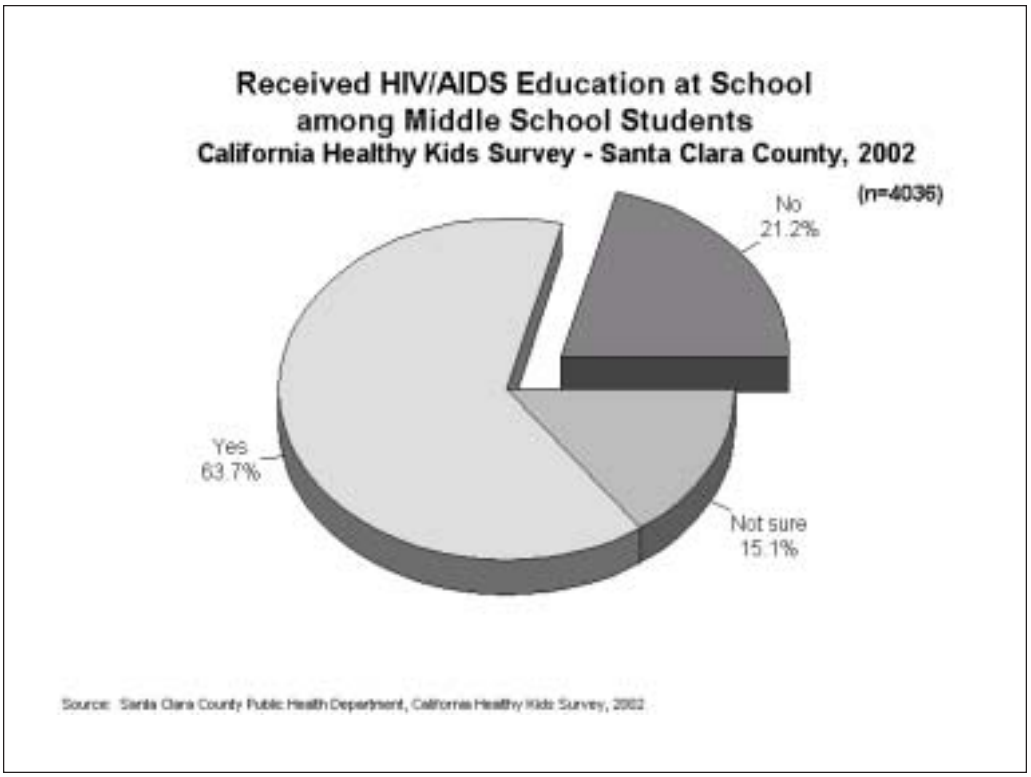


Figure 45



HIV / AIDS continued

Figure 46



Tuberculosis

BACKGROUND

Tuberculosis (TB) was once the leading cause of death in the United States. It is caused by a bacteria called Mycobacterium tuberculosis. The bacteria can attack any part of your body, but usually attacks the lungs. TB is spread from person to person through the air, and symptoms include feeling sick or weak, weight loss, fever, and night sweats. Symptoms of TB of the lungs include coughing, chest pain, and coughing up blood.[51]

People who are infected with latent TB do not feel sick, do not have any symptoms, and cannot spread TB. If a latent TB infection is detected, it can be treated and cured. Untreated, it may develop into TB disease.[51]

In Santa Clara County, there is a public health mandate for the tuberculin skin test (TST) in county schools. The TST determines whether a person is infected with the TB bacteria, but it does not tell whether a person has active TB disease. All students registering for kindergarten must have completed the TST within eighteen months prior to kindergarten entry or transfer, and all students transferring from schools outside the county must have completed the TST within six months prior to entry into grades one through twelve.

HOW ARE WE DOING?

Table 20
Rate of Tuberculosis per 100,000 population by Age Group

	Age 0-4	Age 5-14
Santa Clara County 1996-2001 average *	5.37	1.94
California 2001 **	4.70	1.60

*Santa Clara County Health Department, TB Records, 1996-2001

**California Department of Health Services, 2001

KEY FINDINGS

Santa Clara County's average annual childhood TB rate decreased by half from 1996 to 2001 (Figure 47). The total number of TB cases among Santa Clara County children age 0 to 19 from 1996 to 2001 was 120. The overall TB rate for all ages was higher among males than females; however, in children with TB (age 0–19), the rate in females was higher than in males (Figure 48). The TB rate was lower for children age 5 to 14 years than for children under age 5 (Figure 49). At age 15 to 17 years, the TB rate increased through ages 18 and 19. Overall, the highest TB rates were seen in those age 20 and over. The majority of childhood TB cases from 1996-2001 were pulmonary (pertaining to the lung) (Figure 50).

Hispanics and Asians/PIs age 0 to 19 had the highest rates of TB (Figure 51). The majority of childhood TB cases were among Asian/PIs (52%) and Hispanics (36%). Among Hispanics, TB rates were higher in the under-5 age group than in those age 5 to 19. For Asians/PIs, TB rates were higher in the 5 to 19 age group than in the under-5 age group. After age 5, the highest rates of TB were seen in Asians/PIs (Figure 52). Among Asians/PIs under age 20, about 36% of those with TB were born in Vietnam, 29% in the Philippines, and 19% in the United States. Among Hispanics under age 20, approximately 53.5% of those with TB were born in Mexico, and 44% in the United States (Figure 53, 54).

Tuberculosis continued

Figure 47

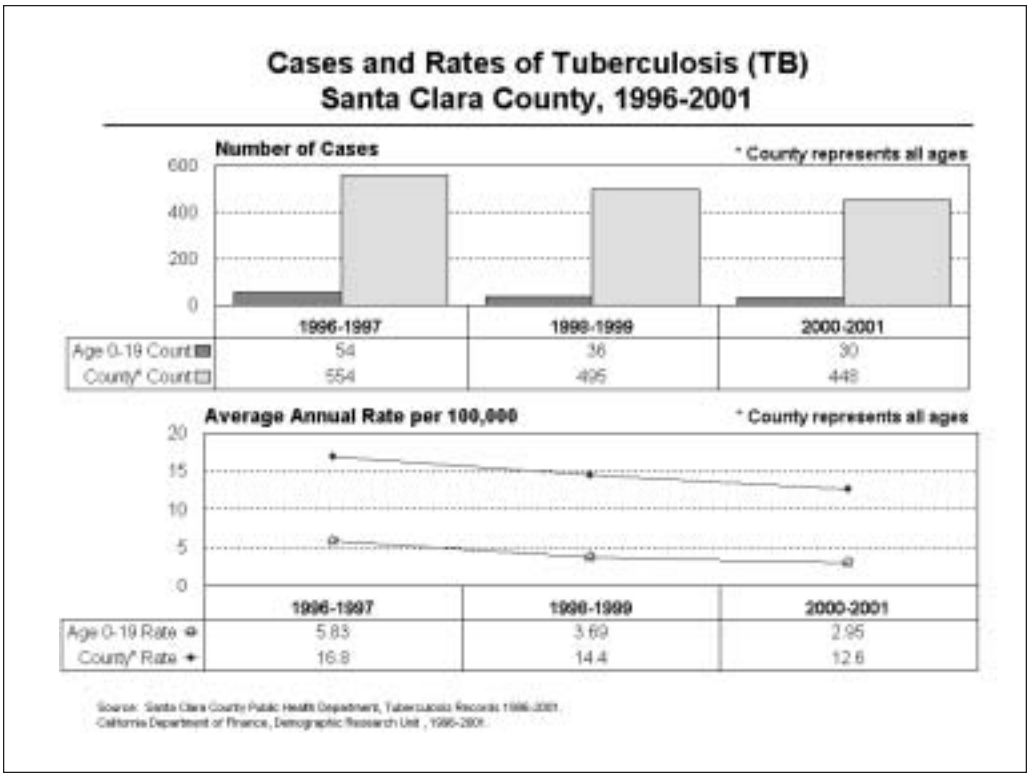
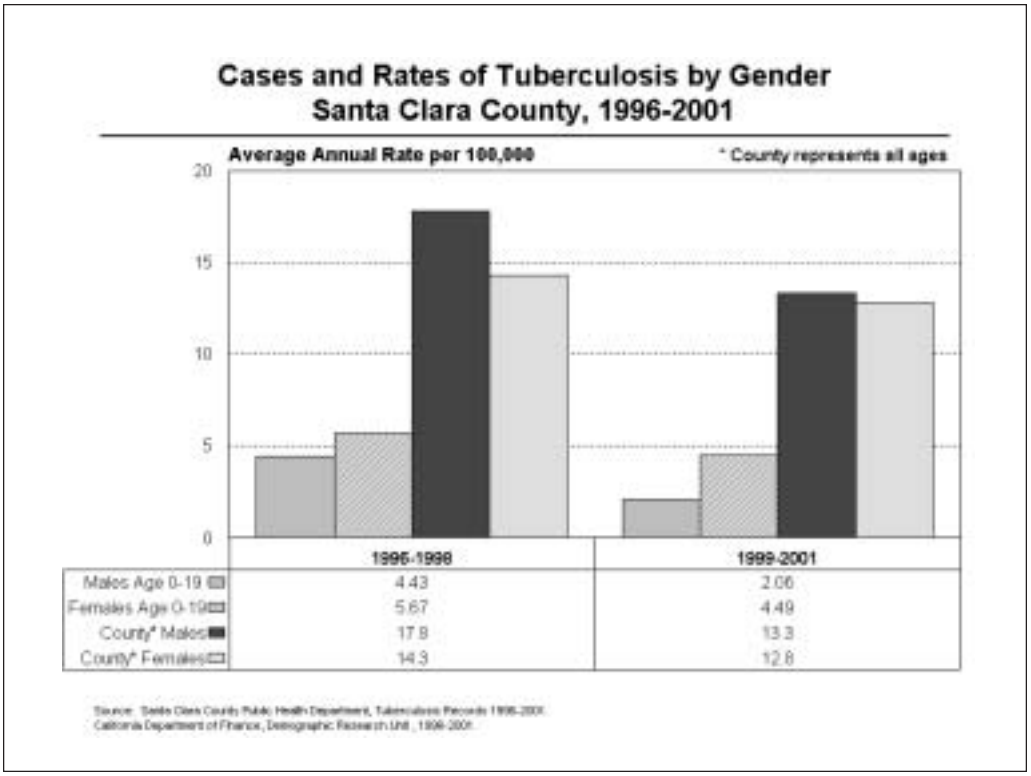


Figure 48



Tuberculosis continued

Figure 49

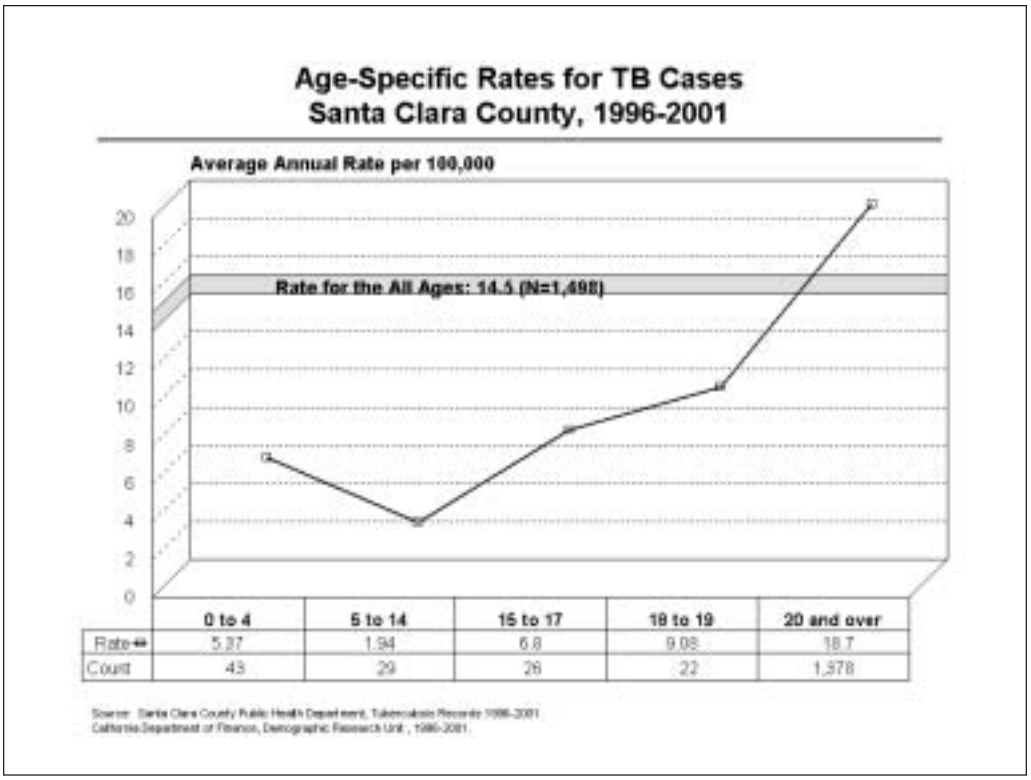
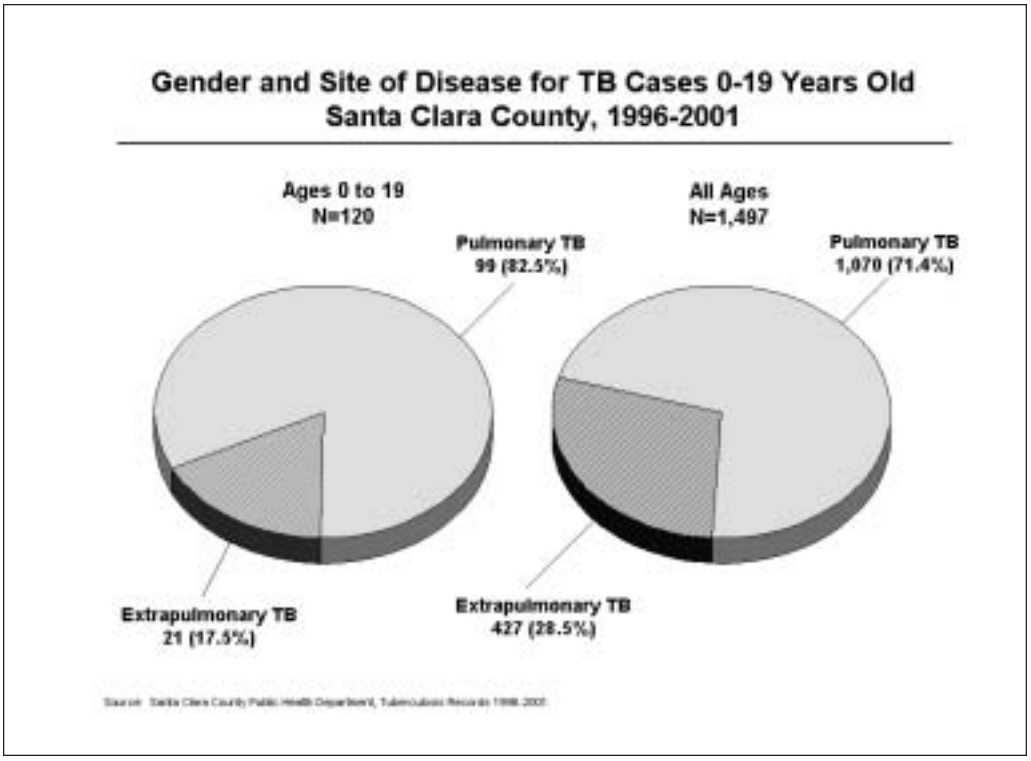


Figure 50



Tuberculosis continued

Figure 51

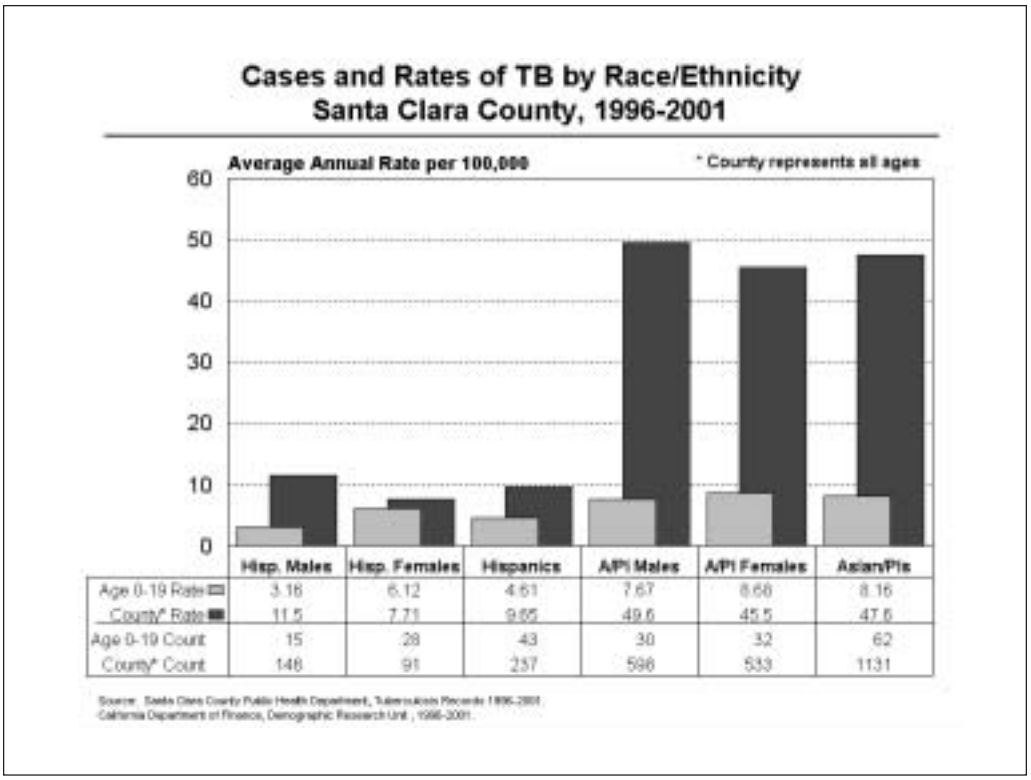
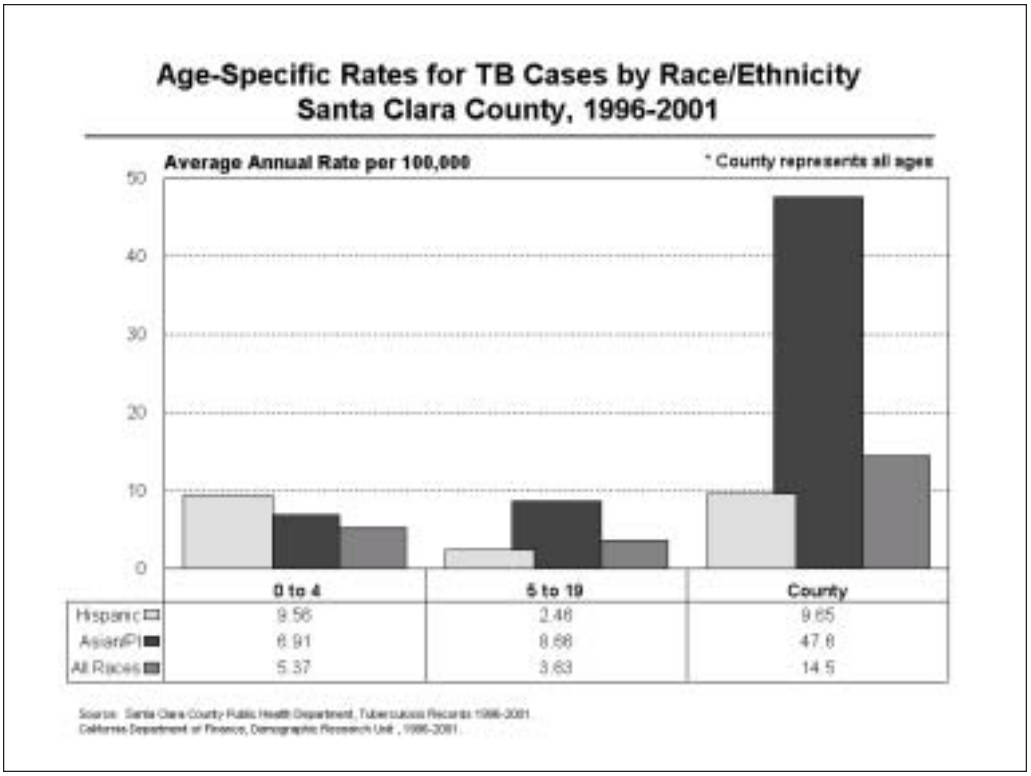


Figure 52



Tuberculosis continued

Figure 53

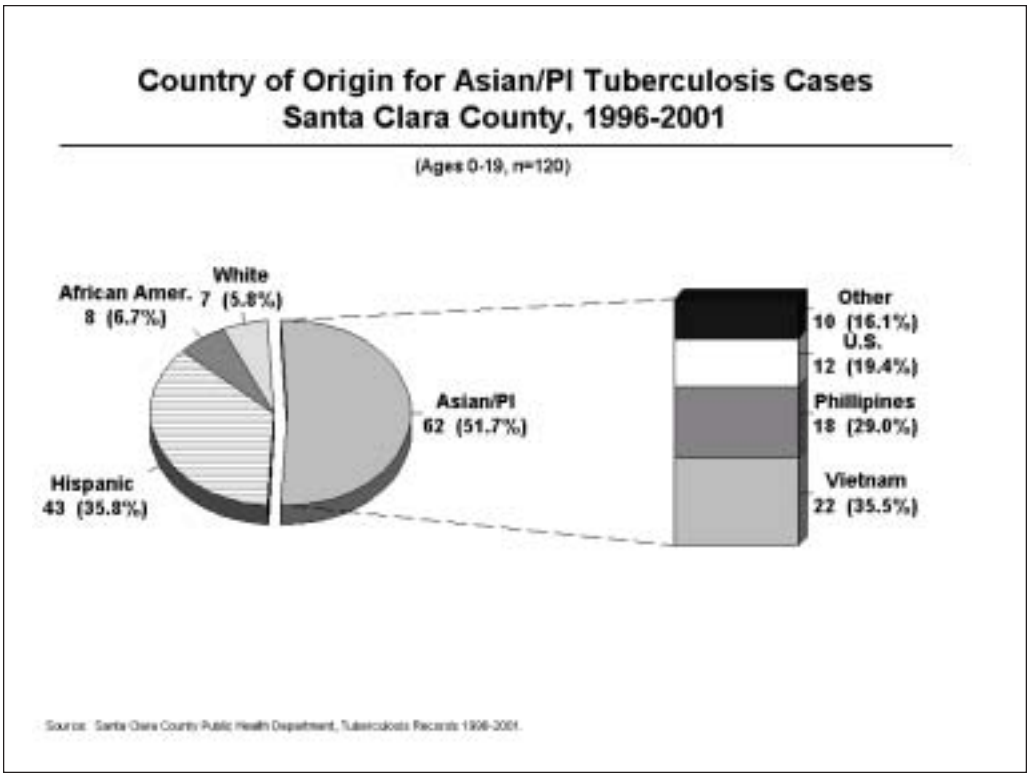
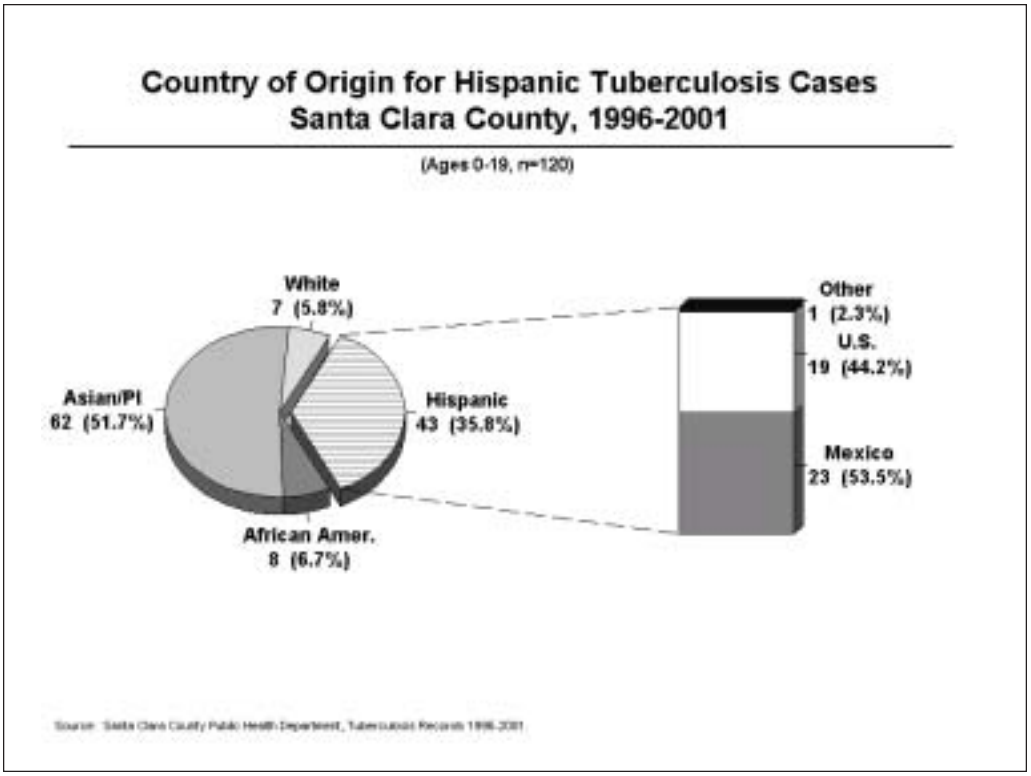


Figure 54



Hepatitis B

BACKGROUND

Hepatitis B is a vaccine-preventable disease transmitted though parenteral or mucous membrane exposure to the blood and other body fluids of individuals infected with the hepatitis B virus (HBV). It is also transmitted from mother to infant during birth. An estimated 90% of infants who become infected through perinatal transmission will have chronic hepatitis, and up to 25% will die of chronic liver disease as adults.[52]

The Santa Clara Public Health Department, under State mandate, collects data on pregnant women with Hepatitis B infections and offers case management services, including vaccination of infants for 18 months.

KEY FINDINGS

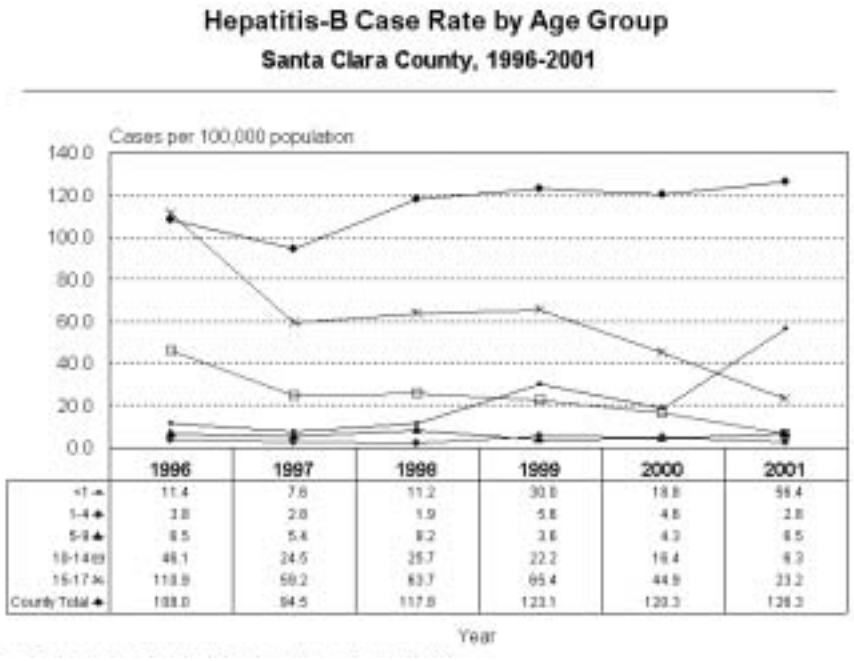
The county rate of Hepatitis B increased between 1996 and 2001. This could be a reflection of increased/better reporting or immigration/importation of new cases (Figure 55). Rates among children and youth between ages 10-17 decreased during these years. However, the rate for infants under one year of age in 2001 was five times higher than the rate seen in 1998.

Data on mothers in the Perinatal Hepatitis B Program in Santa Clara County can serve as a proxy for the race/ethnicity distribution of Hepatitis B, especially for the infants (Figure 56). A majority of women (95%) were of Asian/PI origin in 2000 and 2001.

For 1999 and 2000, about 73% of the children born to women who had a positive test for the Hepatitis B antigen (HbsAg), completed their three-dose vaccine for the Hepatitis B virus within six and eight months from birth (Figure 57). About 12% of the children did not receive a vaccine.

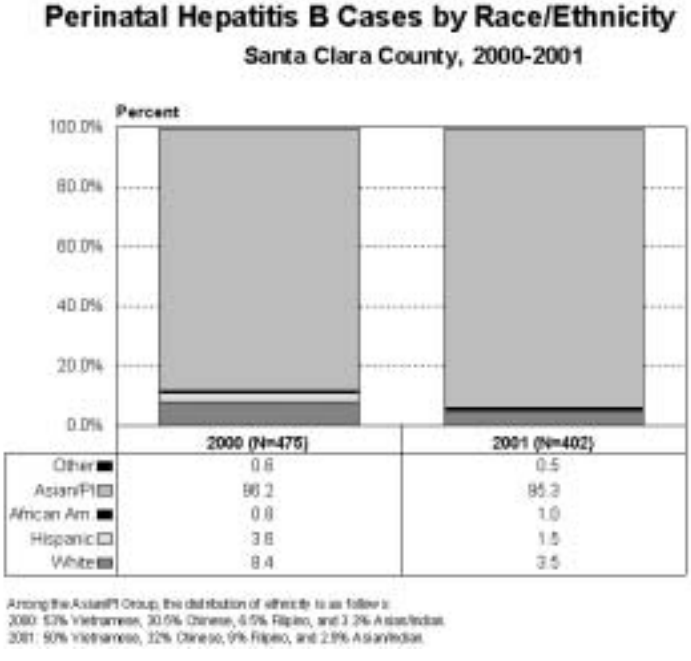
Hepatitis B continued

Figure 55



Source: Santa Clara County Public Health Department, Morbidity Records 1996-2001

Figure 56

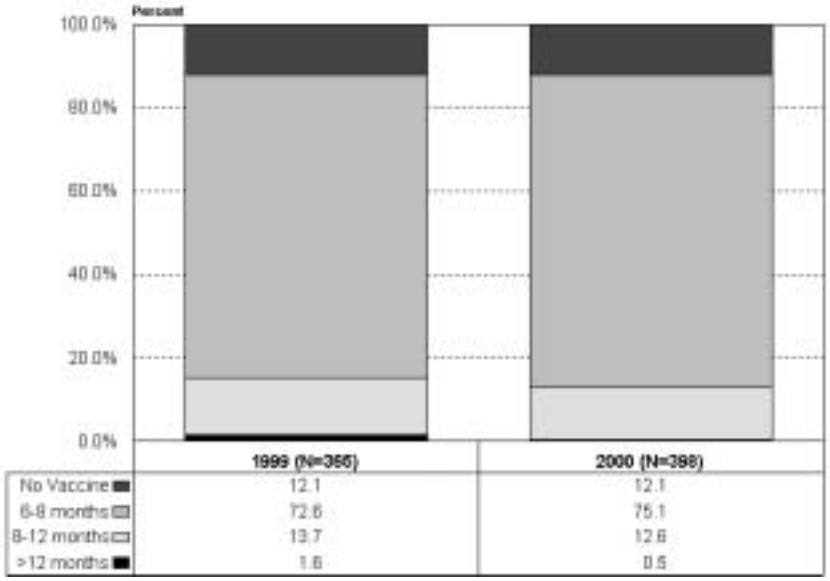


Source: Santa Clara County Public Health Department, Morbidity Records 1996-2001

Figure 57

Length of time from birth to completion of HBV Vaccine Series

Santa Clara County, 1999-2000



	1999 (N=365)	2000 (N=388)
No Vaccine	12.1	12.1
6-8 months	72.6	75.1
8-12 months	13.7	12.6
>12 months	1.6	0.5

Source: Santa Clara County Public Health Department, Morbidity Records 1996-2001

Healthy Behaviors

Individual behavior has a tremendous impact on children's lives and health. Choices children make about food, alcohol, tobacco products and drugs make a difference in their physical, social and emotional well-being. Healthy behavior indicators in this section include body weight, physical activity, nutrition, substance abuse, teen births, and sexual behavior.

Physical Activity

BACKGROUND

"The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity" report (1999) encourages children to accumulate at least 60 minutes of moderate physical activity most days of the week and to limit TV time to less than two hours a day.[53]

Adolescents and young adults benefit from physical activity, which builds and maintains healthy bones, muscles, and joints; controls weight; prevents or delays the development of high blood pressure; and helps reduce blood pressure in some adolescents with hypertension. The activity need not be strenuous to be beneficial.[54]

A recent study conducted by the California Department of Education in 2001 found that physical well-being of students had a direct impact on their ability to achieve academically. The study matched scores from the spring 2001 Stanford Achievement Test, Ninth Edition (SAT-9) with results from the 2001 state-mandated physical fitness test, Fitnessgram, of 5th, 7th, and 9th grade students in the state.[55] Results from this study, along with the prevention against overweight and obesity have proven the benefits of physical activity.

HOW ARE WE DOING?

Table 21
Percent of Adolescents Who Engage in Physical Activity and Percent Who Watch TV for Two Hours or Less Per Day

	Moderate Physical Activity	Vigorous Physical Activity	Watch TV for two hours or less per day
Santa Clara County 2002 (9th, 11th grade)	31.5	67.4	45.8
California	NA	NA	NA
Healthy People 2010 Objective (9th-12th grade)	30.0	85.0	75.0

Source: Santa Clara County Public Health Department, California Healthy Kids Survey 2002

Physical Activity continued

KEY FINDINGS

In Santa Clara County, nearly half of the high-school students surveyed indicated that they exercised at least five days during the week prior to taking the survey (Figure 58). Approximately 10% reported doing no exercise at all. More males than females exercised five days or more during the last week. Whites and African American students exercised more frequently than Hispanics and Asian/PI students. The proportion of students who exercised decreased significantly among higher graders.

Overall, 53% of students watched two or more hours of TV during school days (Figure 59). Significantly more males than females watched two or more hours of TV on a school day.

Each California school district must administer the California Physical Fitness Test (Fitnessgram), developed by the State Board of Education, to students in grades 5, 7, and 9. The test is comprised of six fitness standards: (1) aerobic capacity, (2) body composition, (3) abdominal strength and endurance, (4) trunk extensor and flexibility, (5) upper body strength and flexibility, and (6) overall flexibility.[56] During the 2001-2002 school year, 22% of fifth graders, 30% of seventh graders, and 30% of ninth graders in Santa Clara County passed all six of the fitness standards. Approximately 54% of these students passed five or all of the six fitness standards. The percentages of students who did not pass any of the six fitness standards were 3% of fifth graders, 3% of seventh graders, and 2% of ninth graders.[57]

Figure 58

Days of Physical Exercise in the Past Week

California Healthy Kids Survey - Santa Clara County, 2002

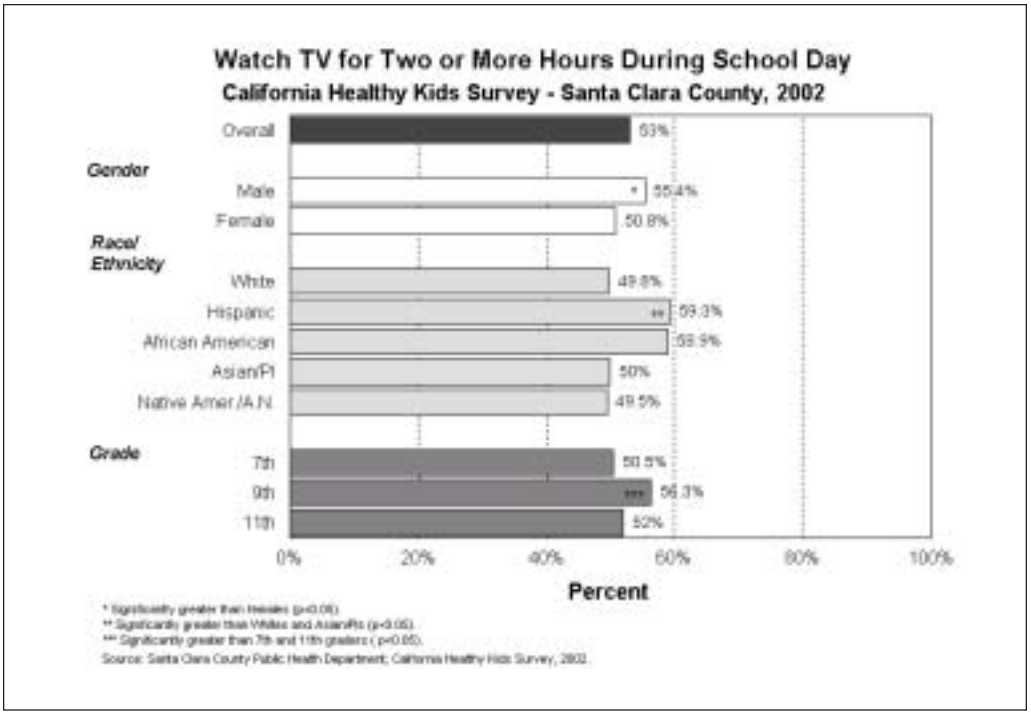
	0 days	1-4 days	5-7 days
Overall	9.7%	42.6%	47.7%
Gender			
Male	7.7%	39.0%	53.4% *
Female	11.6%	45.8%	42.6%
Race/Ethnicity			
White	7.6%	39.9%	52.5% **
Hispanic	9.5%	44.0%	46.5%
African American	8.8%	37.5%	53.7% **
Asian/PI	12.5%	45.3%	42.2%
Native Amer./A.N.	14.5%	37.9%	47.6%
Grade			
7th	5.7%	37%	57.3% ***
9th	6.1%	43.3%	50.6%
11th	17.4%	47.6%	35.0%

* Significantly greater than females (p<0.01).
** Significantly greater than Hispanic and Asian/PIs (p<0.01).
*** Significant trend increasing grade level (Chi Square for trend, p<0.01).

Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

Physical Activity continued

Figure 59



Body Weight

BACKGROUND

The incidence of childhood obesity has increased dramatically in recent years. In the United States in 1999, 13% of children age six to 11 and 14% of adolescents age 12 to 19 were overweight. Prevalence levels have nearly tripled for adolescents in the past two decades. Poverty has been shown to be correlated with childhood obesity, anemia, and poor nutrition.[36]

The most immediate consequence of being overweight, as perceived by children themselves, is social discrimination, which is associated with poor self-esteem and depression. Although not recommended by health professionals, diet pills and crash diets are often employed to control body weight. In addition, overweight adolescents have a 70% chance of becoming overweight or obese adults – this chance increases to 80% if one or more parents is overweight or obese. Overweight or obese adults are at risk for a number of health problems including heart disease, type 2 diabetes, high blood pressure, and some forms of cancer.[36]

HOW ARE WE DOING?

Table 22
Percent of high school students who responded "overweight" when asked, "How do you describe your weight"

Santa Clara County (2001)	32.9
California	NA
National YRBS (2001)	29.3

Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

KEY FINDINGS

Infants & Children

In Santa Clara County, there are two sources of data on obesity and nutrition among young children: WIC (Women, Infants, and Children) and CHDP (Child Health and Disability Prevention) programs. Although the data are not representative of the entire county population, it highlights children living at the poverty and/or low-income levels. WIC data from January 2001 indicated that 24% of the 2,657 three- to four-year olds enrolled in the program were overweight and 19% of the 3,718 children between one and two years of age were overweight.

Based on the 2000 CHDP data, 17% of children between age 5- and 20-years were identified as being at risk of being overweight. About 16% of children between age two and five years were at risk of overweight.

Adolescents

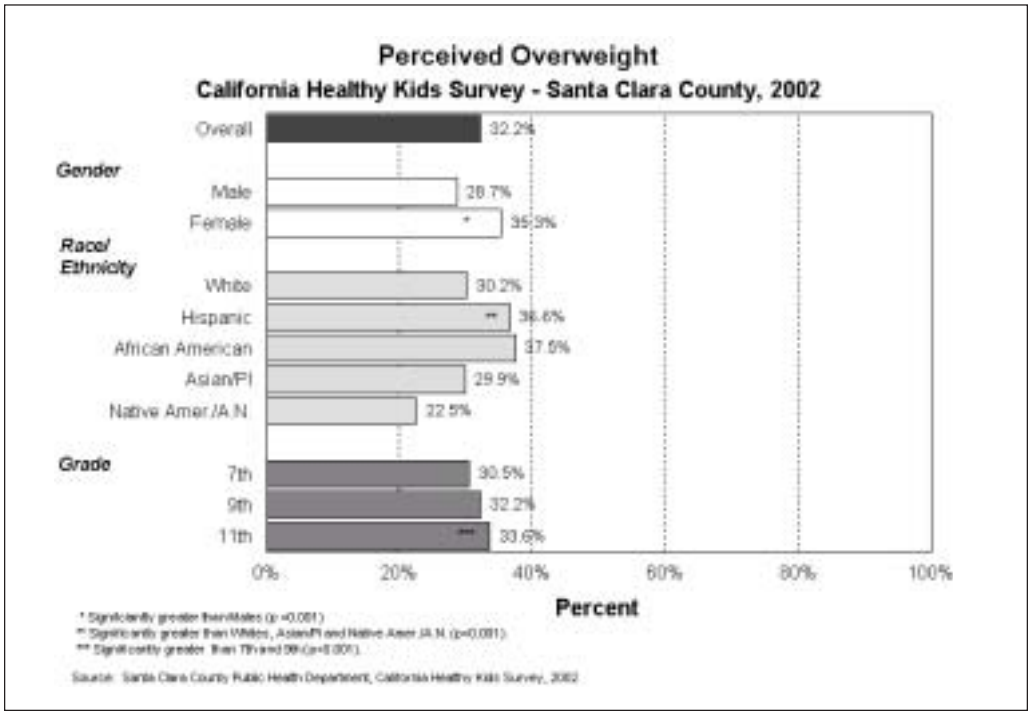
Among the Santa Clara County junior-high and high-school students surveyed, 32% felt that they were overweight (Figure 60). The perception was much higher among female students (35%) than among the male students (29%). More Hispanic students perceived themselves as overweight (37%) compared to Whites, Asians/PIs, and Native Americans. Eleventh graders had a significantly higher perception of being overweight than 7th graders and 9th graders.

About two-thirds of students exercised to lose weight (Figure 61). Females were significantly more likely to exercise and control their diet to lose weight than males. (Figure 61, 62). Hispanic students (46%) reported most often that they were controlling diet to lose weight, compared to other race/ethnicity groups. A higher

Body Weight

proportion of 9th graders (70%) reported exercising to lose weight compared to 7th and 11th graders. Overall, 7% of students reported that they were taking pills to lose weight (Figure 63). Approximately 6% of students reported taking a laxative to lose weight. Female students reported taking a laxative to lose weight significantly more often than males, 7% versus 5% respectively. Native American students, more than any other race/ethnicity, reported taking diet pills or laxatives to lose weight (Figure 64).

Figure 60



Body Weight

Figure 61

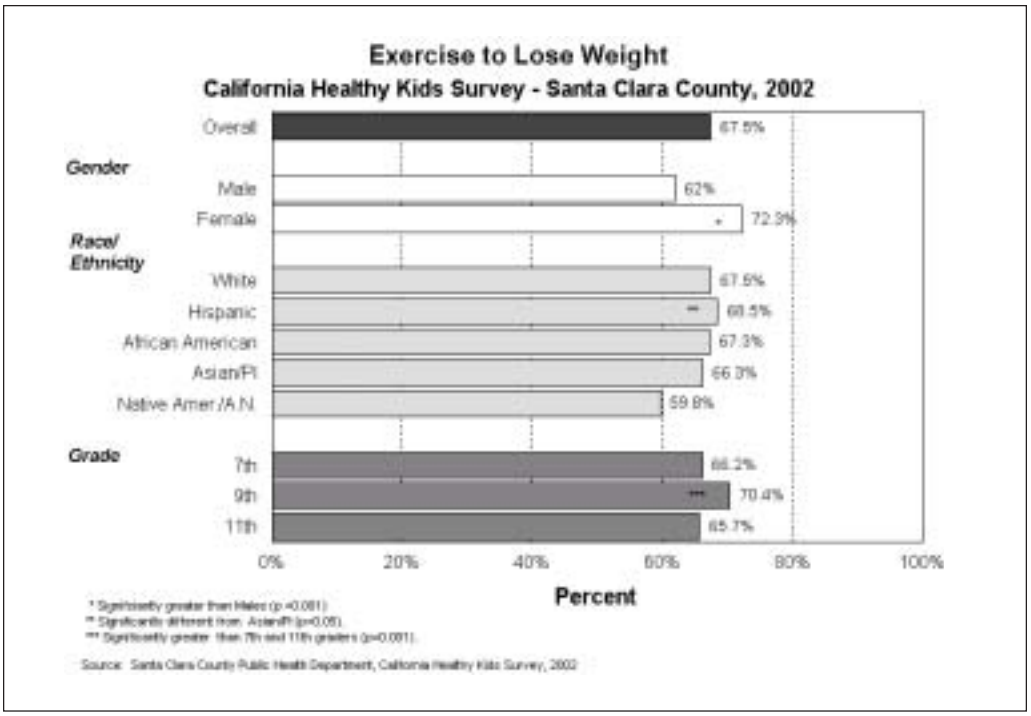
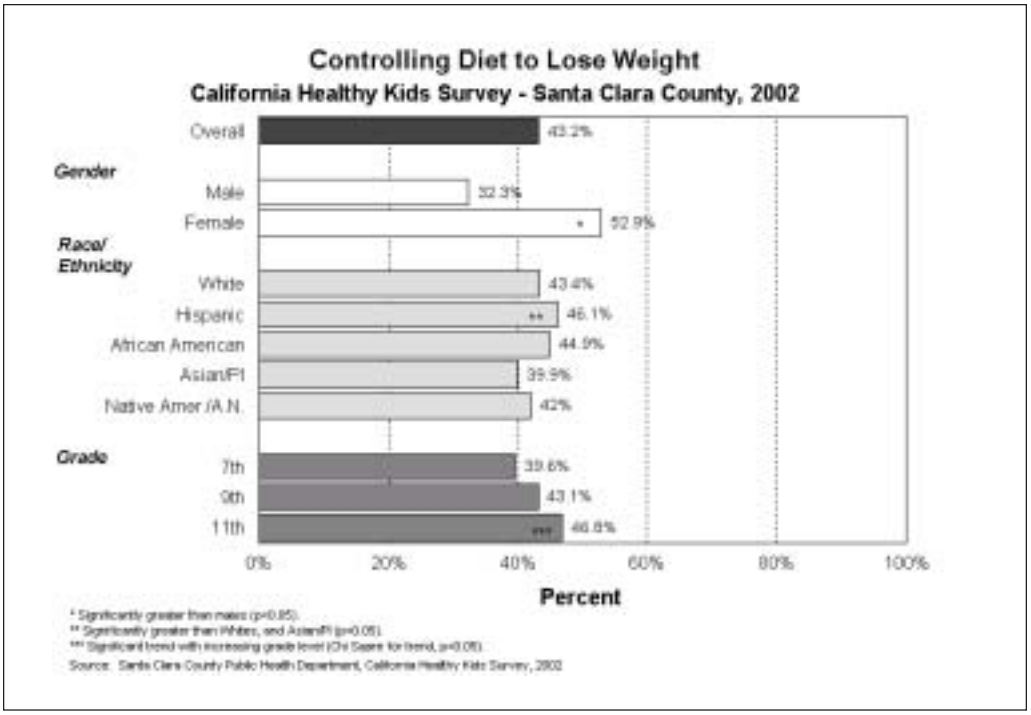


Figure 62



Body Weight

Figure 63

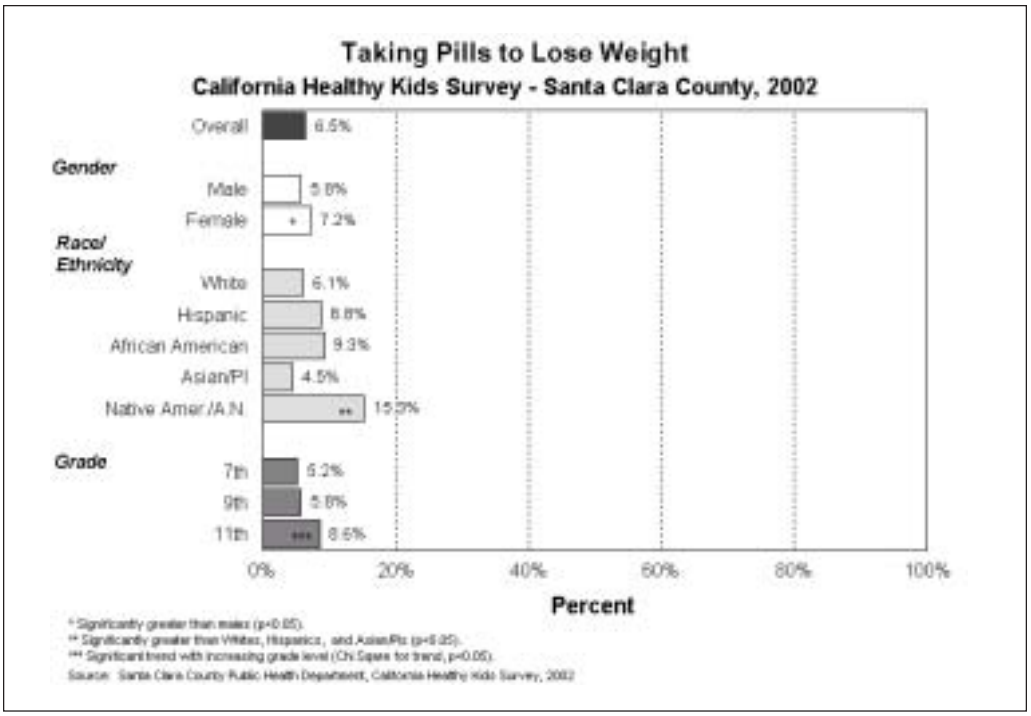
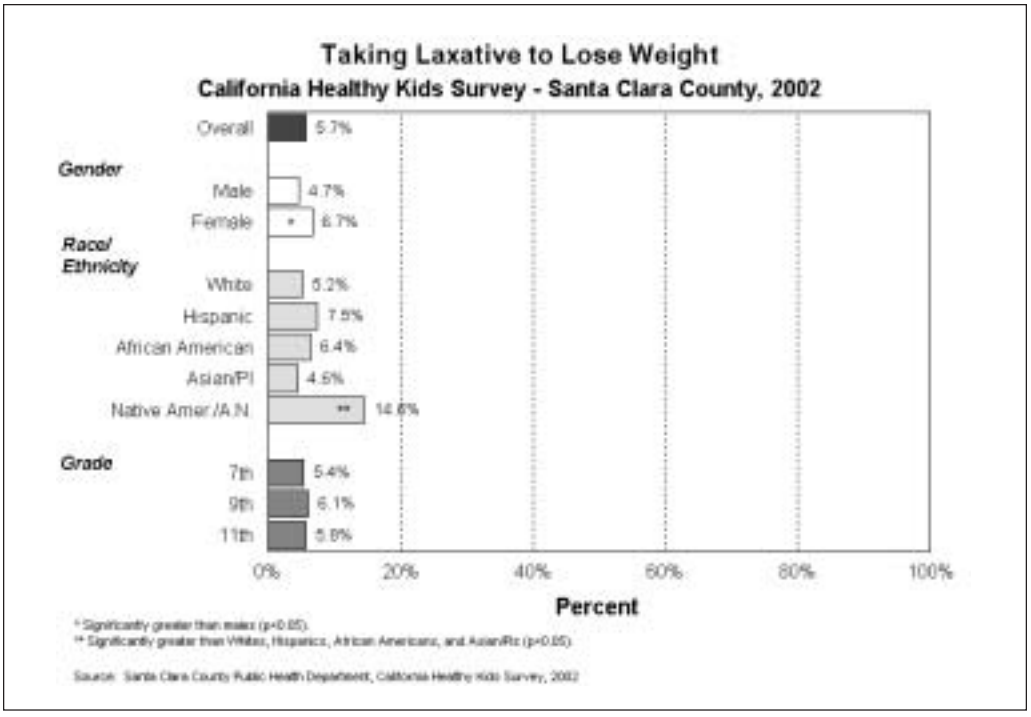


Figure 64



Nutrition

BACKGROUND

Good nutrition is essential for growth, development, health, and well-being. Educating school-aged children about nutrition helps establish healthful eating habits early in life. Research suggests that parents who understand proper nutrition can help preschool children choose healthful foods, but they have less influence on the choices of school-age children. A survey done in 1994 showed that only 69% of states and 80% of school districts required nutrition education for students in at least some grades from kindergarten through 12th grade.

In response to the increasing risks and prevalence of overweight and obesity among California children, SB19, The Pupil Nutrition, Health, and Achievement Act of 2001, was signed by state legislators and governor. The passage of SB19 set new nutrition standards for all food sold at elementary schools and sought to eliminate sodas from elementary and middle schools during meal times to increase the consumption of water, milk, and other healthy drinks. The state also supports the National School Lunch Program (NSLP) and the School Breakfast Program (SBP), which subsidize nutritionally healthy meals at participating schools and provide one third (NSLP) and one fourth (SBP) of a child's dietary recommended daily allowance.[58]

According to the 2000 California High School Fast Food Survey, fewer than 40% of students participated in the NSLP in slightly more than a third of schools that serve a large number of low-income students. At 71% of the school districts surveyed, 70% of all food sales were a la carte items, such as pizza, hamburgers, submarine sandwiches, french fries, chips, cookies, yogurt, bagels, ice cream, and sodas.[59] The School Breakfast Program has had better support, ranking 30th in the nation for participation among low-income students. California's Child Nutrition Task Force is also promoting the School Breakfast Campaign 2003 to further improve the diets of youth in public schools.[60]

HOW ARE WE DOING?

Table 23
Percent of persons aged 2 years and older who consume at least two daily servings of fruit.

Santa Clara County	N/A
Healthy People 2010 Objective	75

KEY FINDINGS

In Santa Clara County, more male students reported eating breakfast the day of the survey than female students (Figure 65). White students were significantly more likely to have had breakfast than all other races/ethnic groups. Seventh graders were more likely to eat breakfast than 9th or 11th graders.

Overall, 78% of all students surveyed reported eating fruits and 81% reported eating vegetables during the past 24 hours (Figures 66, 67). The proportion of African-American students that reported eating fruits in the last 24 hours was significantly lower than any other race/ethnic group. Students in higher grades reported eating fruits less frequently than students in lower grades. Vegetable consumption was highest among Asians/PIs compared to all other races/ethnic groups. Over 50% of students consumed soda or fries at least once in the past day (Figure 68).

Among children participating in the Child Health Disability Prevention program in 2000, 13% of the children had low hemoglobin and hematocrit levels (H/Hct), an indicator of iron-deficiency anemia. About 15% of the children between two and five years of age had iron-deficient anemia.

Nutrition continued

Figure 65

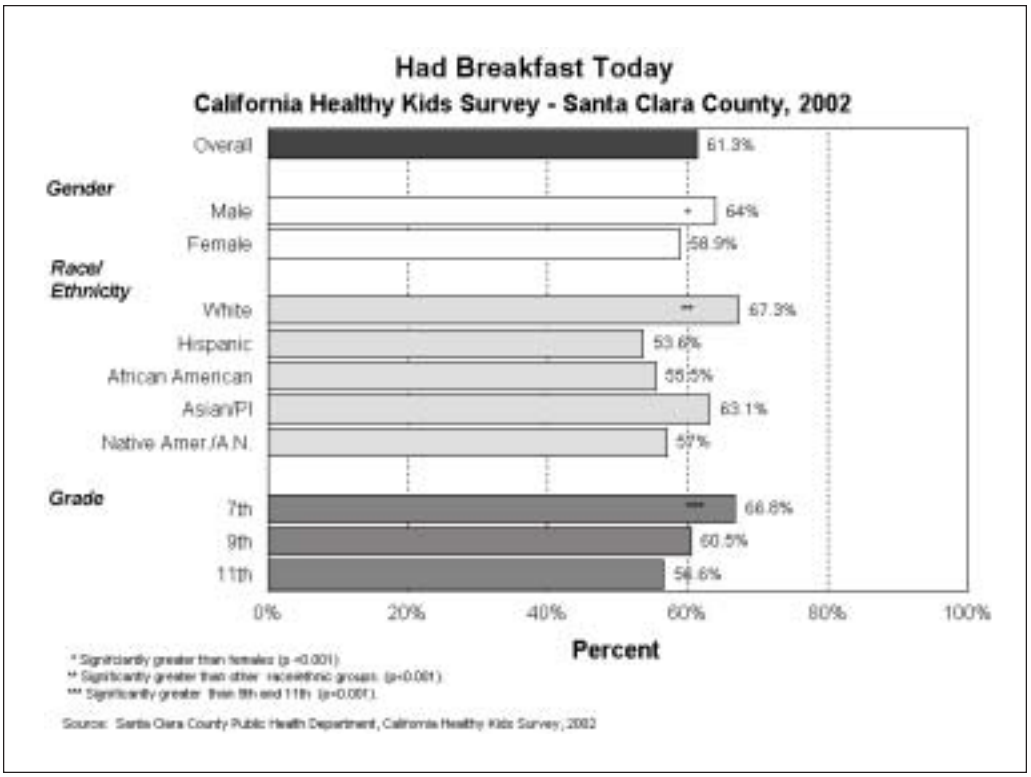
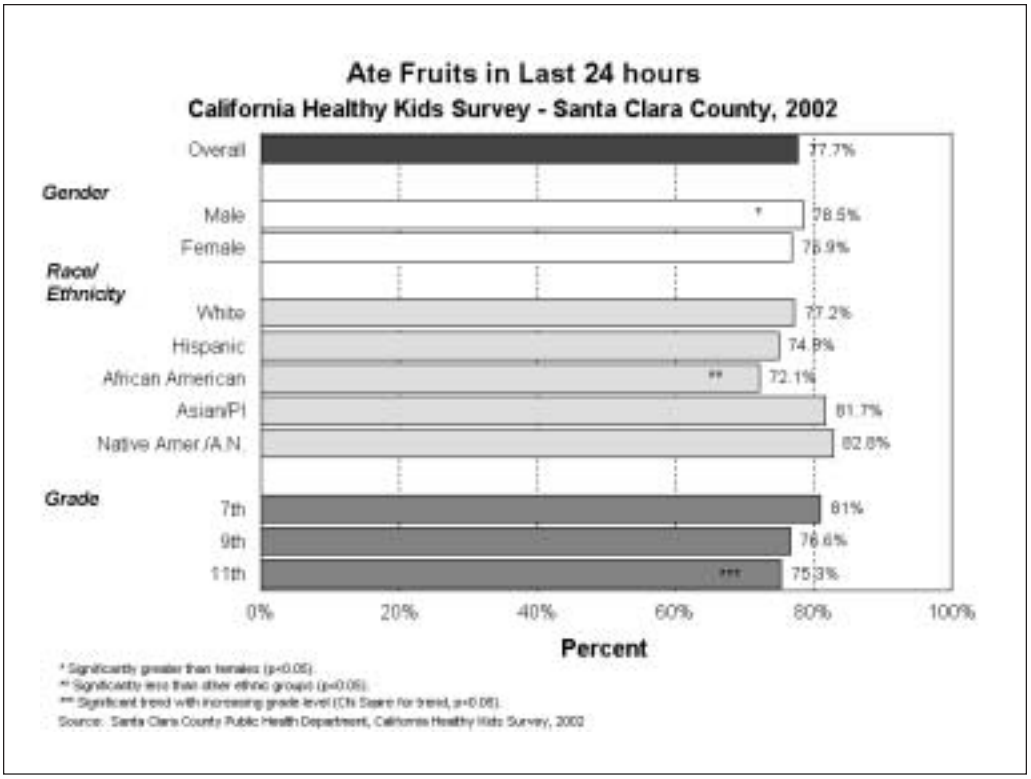


Figure 66



Nutrition continued

Figure 67

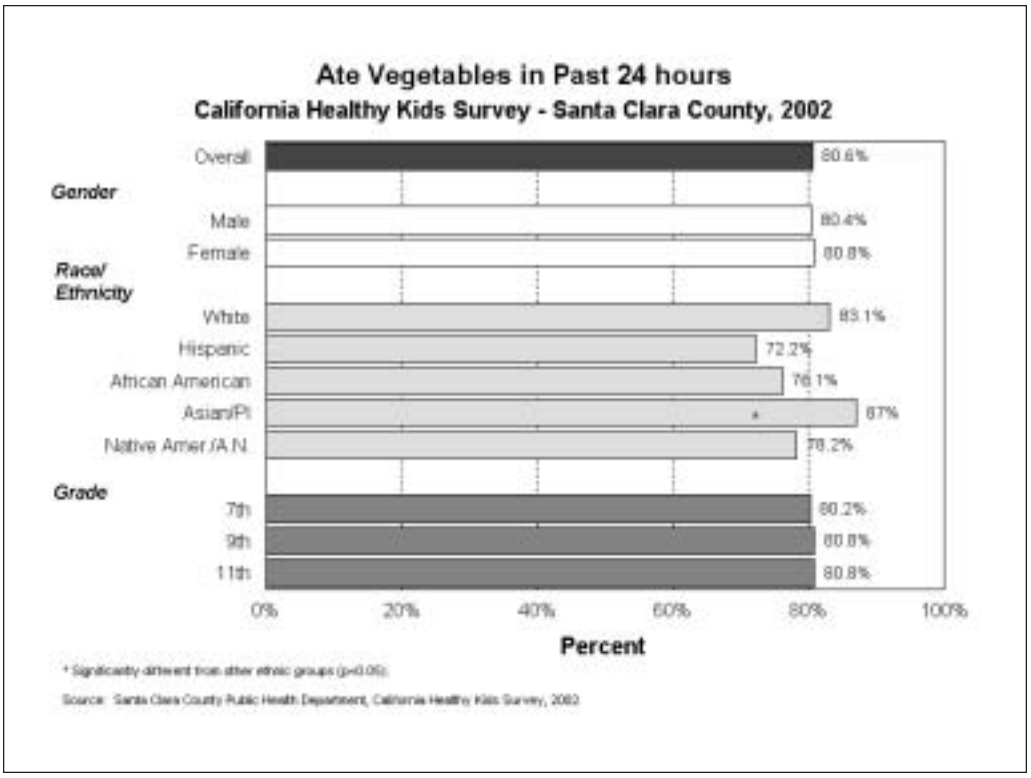
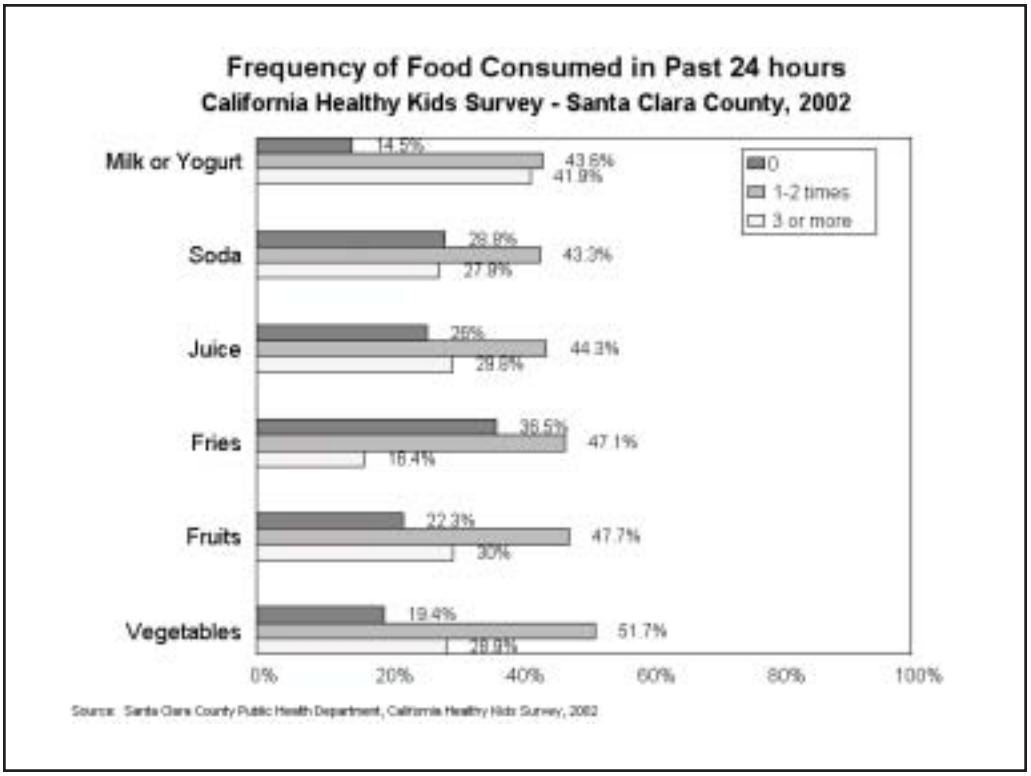


Figure 68



Substance Abuse – Tobacco

BACKGROUND

Smoking among children and teenagers is a major public health problem. Although more than one in four U.S. high school students smoke cigarettes, the rate of teenage smoking has declined since 1997. Adverse health affects from nicotine use by smoking include respiratory illnesses and increased cancer risks for smokers and persons exposed to secondhand smoke.

Using one type of tobacco product increases the likelihood for use of other tobacco products. For example, adolescents using smokeless tobacco are more likely than nonusers to become cigarette smokers. Observing older adults or peers smoking also influences youth to smoke cigarettes.[36, 61]

HOW ARE WE DOING?

Table 24
Percent of High School Students
Who Smoked Cigarettes Past Month

Santa Clara County 2001*	11.2%
California 2001**	15.0%
Healthy People 2010 Objective	16.0%

*Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002
**2001 California CHKS high school students

KEY FINDINGS

About 9% of middle and high school students in Santa Clara County reported that they smoked cigarettes in 30 days prior to the survey, lower than the California results and Healthy People 2010 Objective. The smoking prevalence of Santa Clara County adolescents in 1999 was estimated at 6%. This was a 45% drop from 1996, when the rate was nearly 12%, and a 24.2% drop from 1990, when the rate was 8.4%.

Overall, 31% of Santa Clara County students surveyed reported that they had ever smoked (Figure 69); however, of these students, a smaller portion (18%) reported having smoked a whole cigarette (Figure 70).

About 9% of all students surveyed were current smokers (Figure 71). Current smokers are those who smoked at least once in the 30 days prior to the survey. Current smoker rates were highest for male students, Hispanic males compared to Hispanic females, Asian/PI males compared to Asian/PI females, and 11th grade students compared to 9th and 7th grade students.

Among students who were current smokers, nearly 7% reported that they smoked more than 10 cigarettes on the day they smoked (Figure 72). This percentage increased with grade increases. Males (9%) were nearly twice as likely as females (5%) to have smoked more than 10 cigarettes on the day they smoked. A smaller proportion of Asian/PI (5%) students reported smoking more than 10 cigarettes than other races/ethnic groups.

Frequent smokers are those who smoked 20 or more cigarettes in the past 30 days. Among current smokers nearly 28% smoked frequently (Figure 73). A significantly greater number of males (33%) were frequent smokers than females (23%). Hispanics smoked less frequently compared to any other race/ethnic groups.

Continued…

Substance Abuse – Tobacco continued

Regular smokers are those who smoked at least once everyday in the 30 days prior to the survey (Figure 74). Seven percent of students surveyed were regular smokers.

Among all students who smoked, 4% smoked on school property (Figure 75). A higher proportion of males smoked on school property than females. Whites and Asian/PIs were less likely to smoke on school property.

Approximately 2% of current smokers reported using smokeless tobacco during the 30 days preceding the survey (Figure 76). Among all students who smoked, males had a higher prevalence of using smokeless tobacco than females, Native Americans/Alaskan Natives (7%) had a significantly higher prevalence of using smokeless tobacco than any other race/ethnic group, and 11th graders had greater usage than 9th and 7th grade students.

Overall among high school students, about 14% of those who smoked started smoking before they were 13 years old (Figure 77). There were higher proportions for starting to smoke before age 13 for male than female students, Hispanic students than other ethnic/racial groups, and 11th graders than 9th and 7th graders.

When asked about their likelihood of smoking next year, nearly 8% of 11th graders said that they were likely to smoke one/more cigarettes in the next year, compared to 4% of 9th graders and only 2% of 7th graders (Figure 78).

Nearly 95% of all students perceived that frequent smoking is harmful (Figure 79). Perception of the harm smoking can do was higher among females than males and among White students compared to Hispanic and African American students.

Among all students, 23% perceived difficulty in getting cigarettes.

When asked where they obtained cigarettes, about 25% of 11th graders who smoke reported buying cigarettes at a store (Figure 80). Among 9th grade smokers, more than one-fourth said that they got cigarettes from their friends. Nearly 20% of 7th grade smokers indicated that they obtained cigarettes by stealing, and another 20% said that they obtained cigarettes through friends.

Only 17% of middle school students said that they were asked for proof of age while purchasing cigarettes.

Among students who currently smoke, about half said that they would like to quit smoking. Similarly, about half had tried to quit smoking. More 11th grade students said that they would like to quit smoking than 7th and 9th grade students, and more 11th grade students reported trying to quit. However, there was no significant difference between students of different gender or race/ethnic group when it came to a desire to quit smoking (data not shown). Asian/PIs (63%) had a higher prevalence of having tried to quit smoking than Whites (54%) and Hispanics (54%). Nearly 92% of the students among the current smokers said that they attended a special group session to quit smoking.

Substance Abuse – Tobacco continued

Figure 69

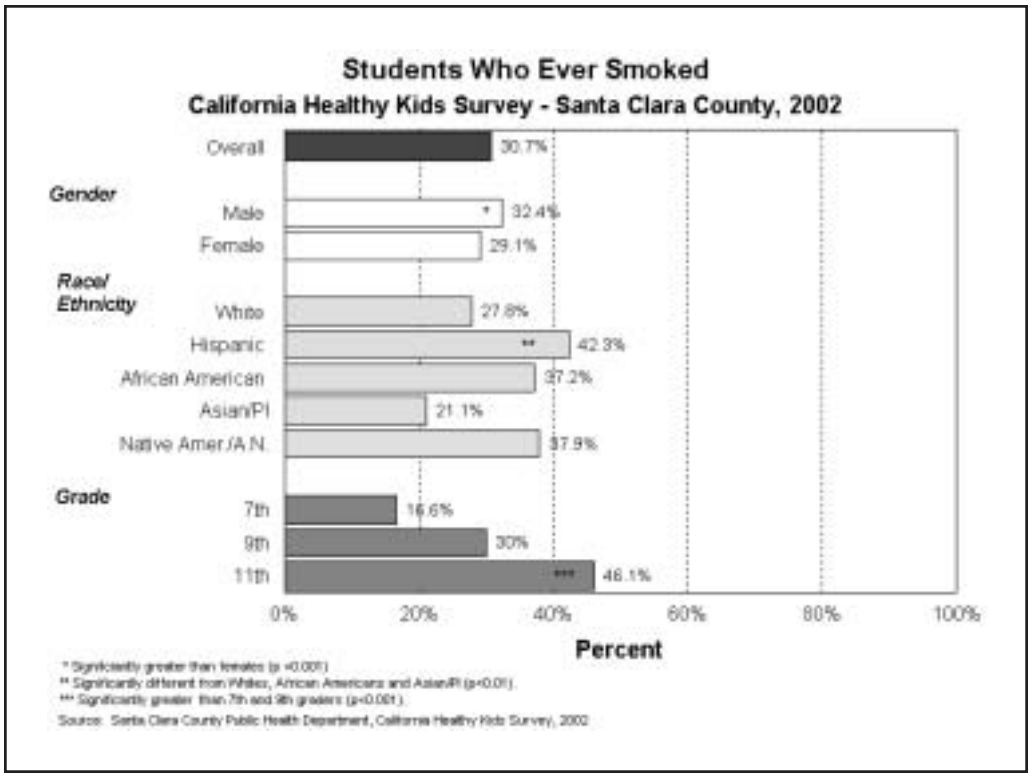
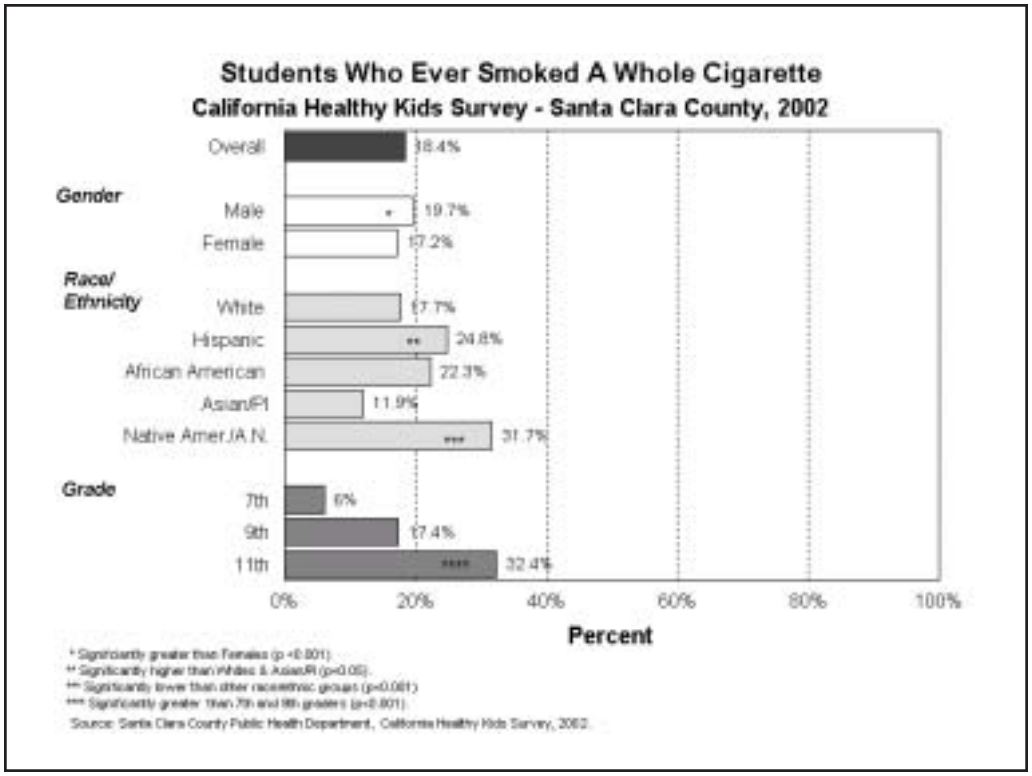


Figure 70



Substance Abuse – Tobacco continued

Figure 71

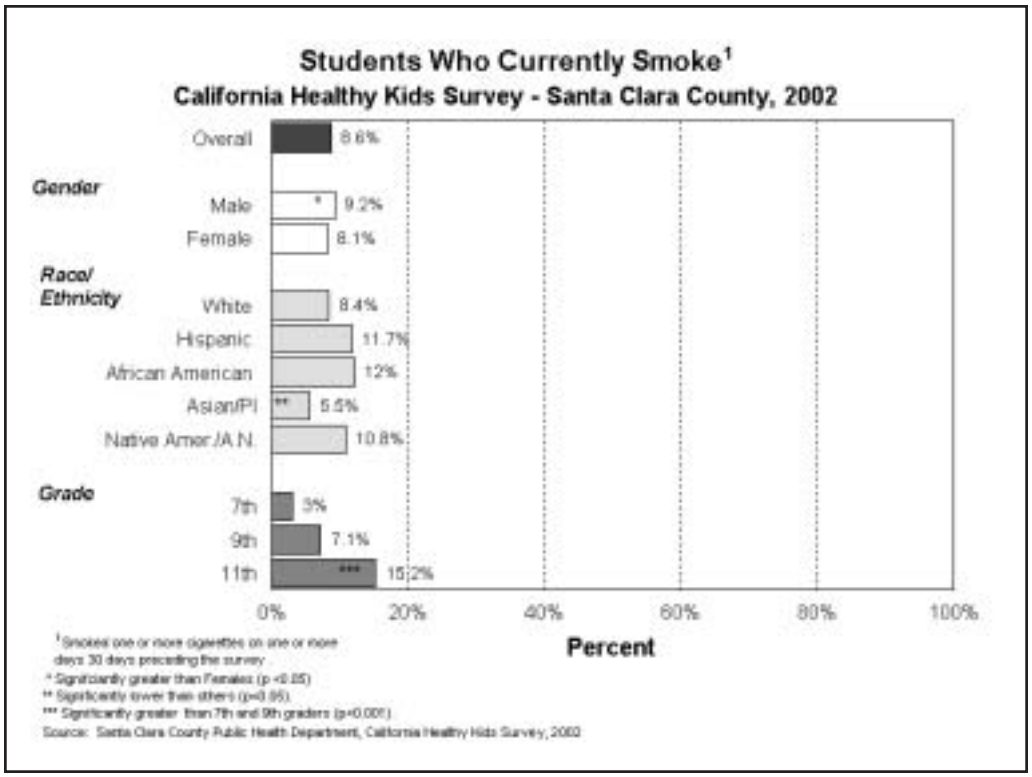
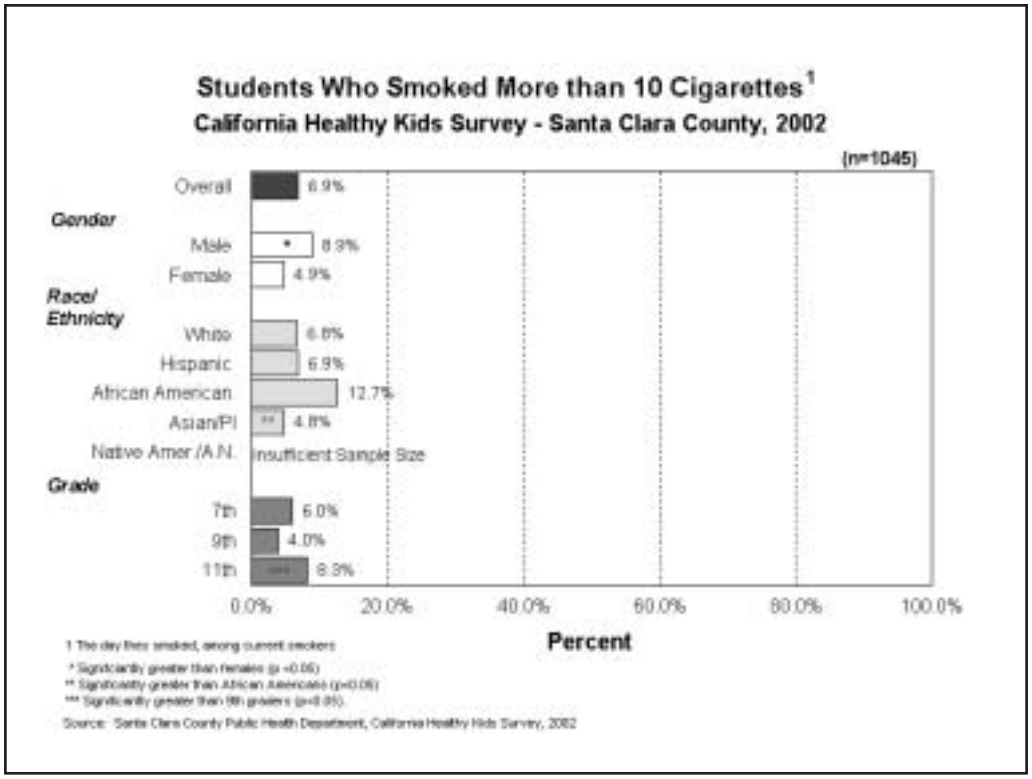


Figure 72



Substance Abuse – Tobacco continued

Figure 73

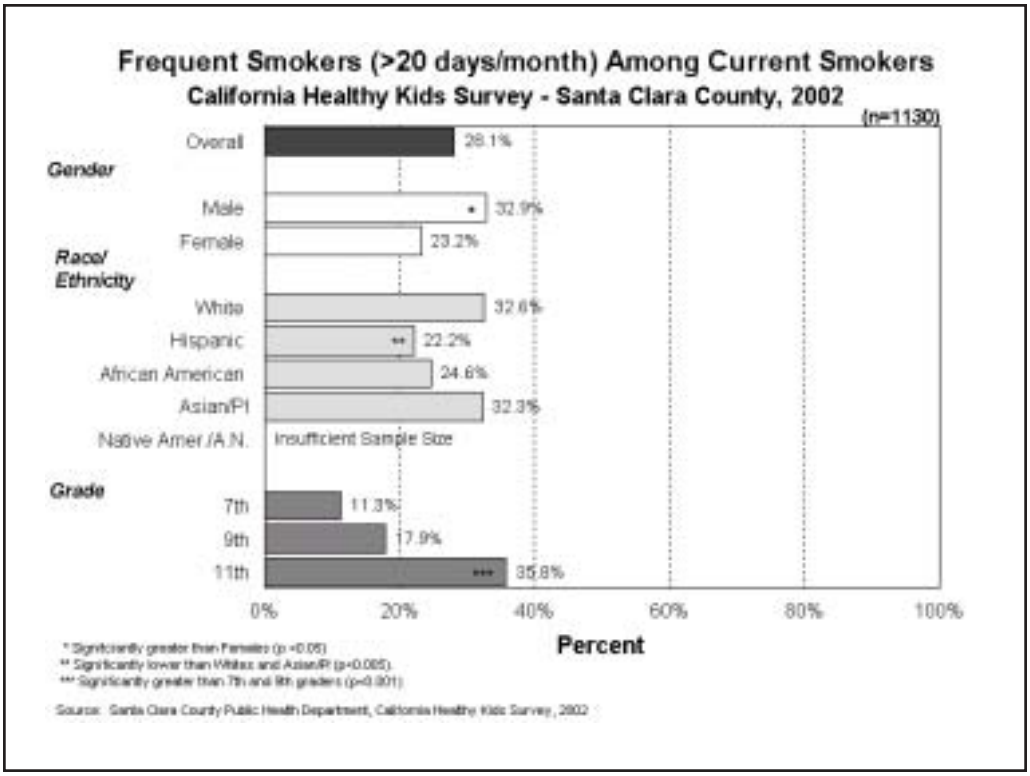
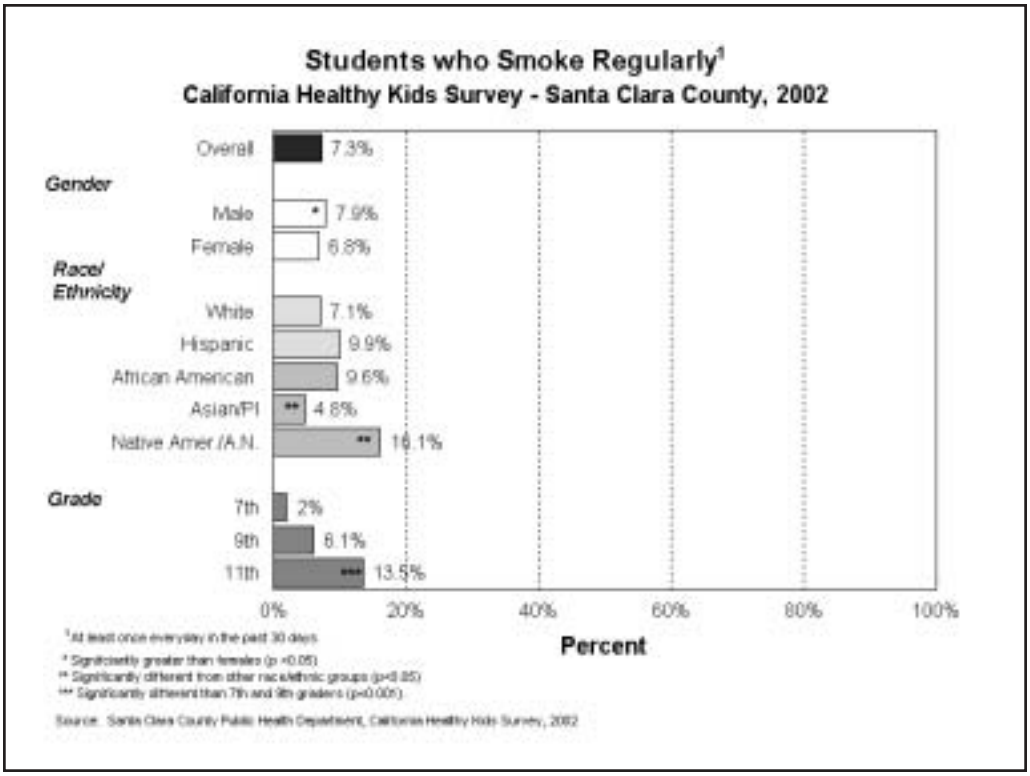


Figure 74



Substance Abuse – Tobacco continued

Figure 75

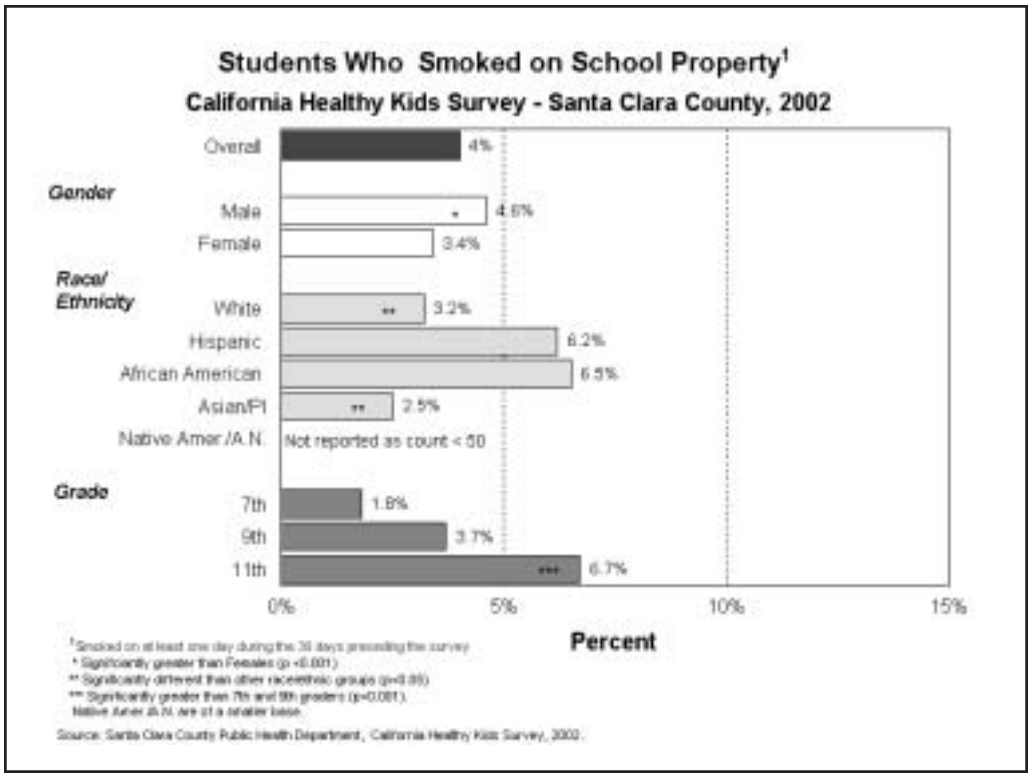
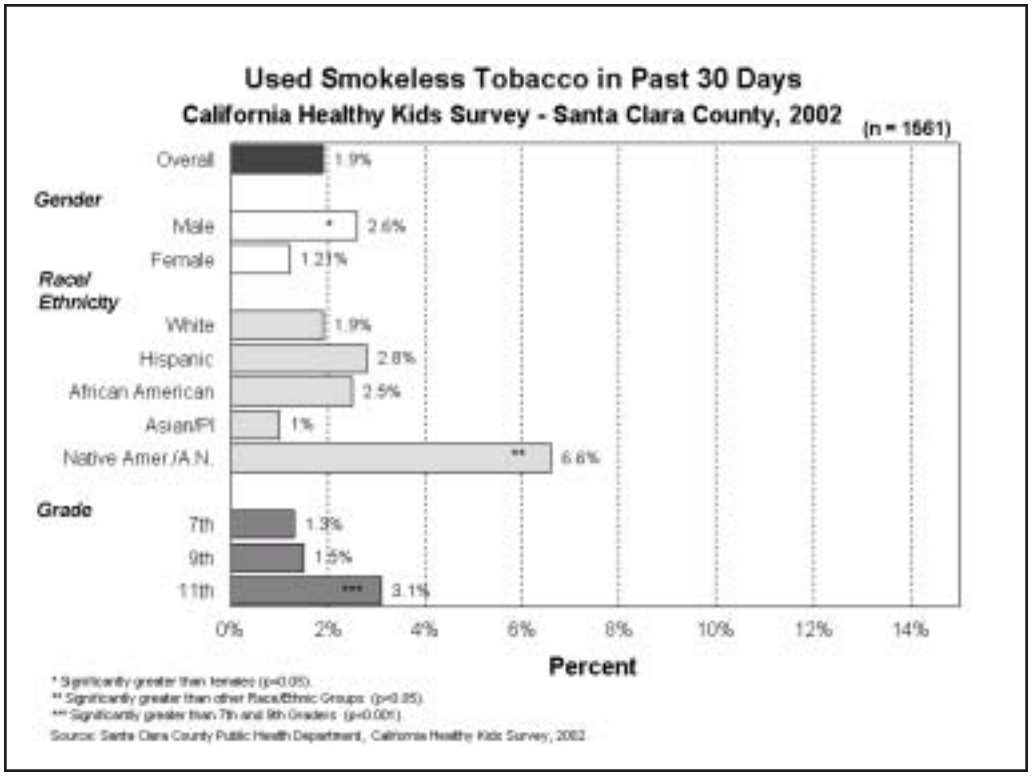


Figure 76



Substance Abuse – Tobacco continued

Figure 77

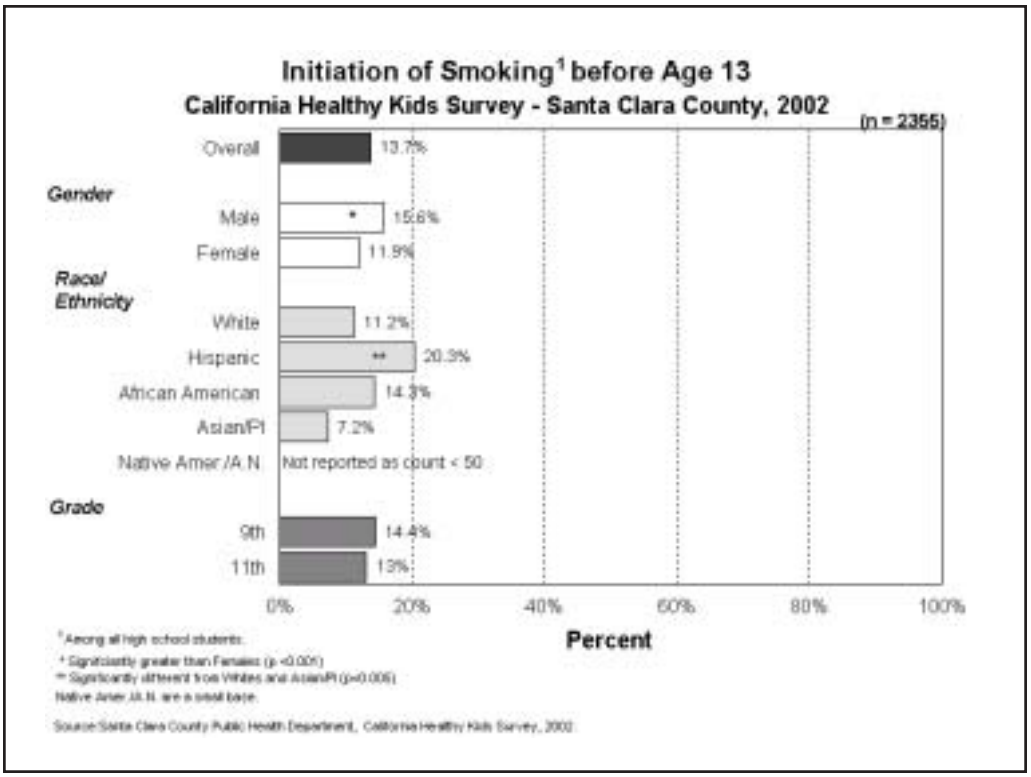


Figure 78

Likely to Smoke One or More Cigarettes in the Next Year by Grade

California Healthy Kids Survey - Santa Clara County, 2002

Likelihood of smoking	7th	9th	11th	Total
Sure will not happen	75%	62.9%	60.2%	63.4%
Probably will not happen	15.2%	19.3%	17.3%	17.9%
Remote Chance it will happen	5.8%	9.2%	7.9%	8.2%
Probably will happen	2.5%	5%	6.8%	5.4%
Surely will happen	1.5%	3.6%	7.8%	5.1%

Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

Substance Abuse – Tobacco continued

Figure 79

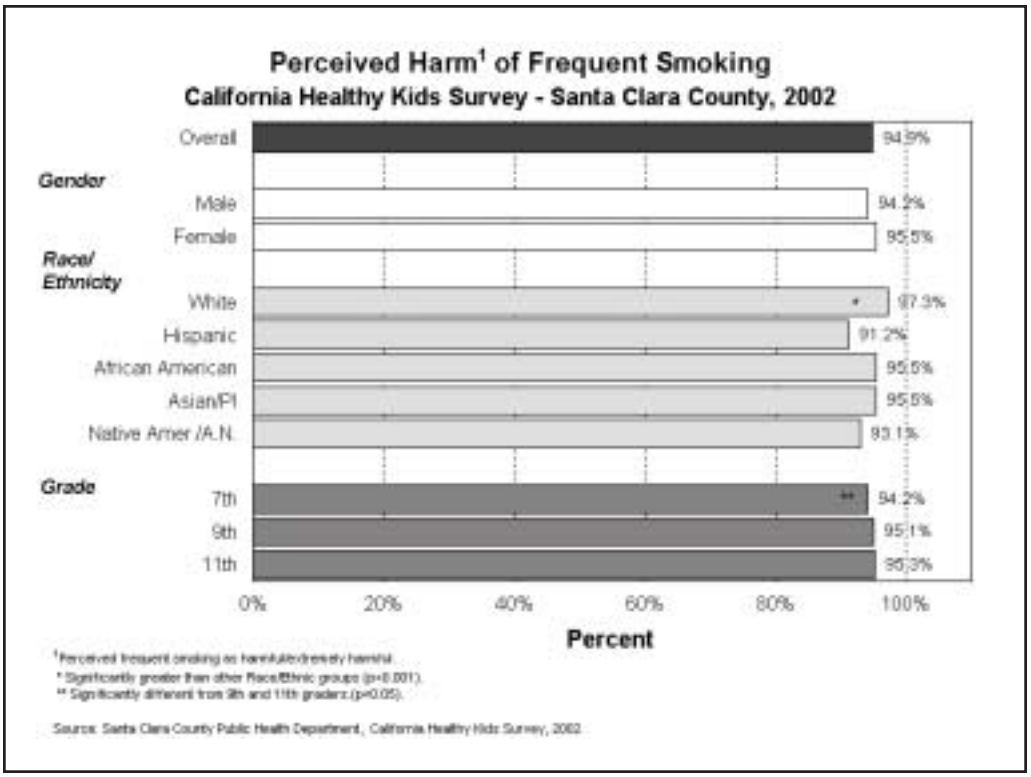


Figure 80

Source of Obtaining Cigarettes by Grade
California Healthy Kids Survey - Santa Clara County, 2002

Source	7th	9th	11th	Total
Friend	21.7%	25.2%	21.1%	22.5%
Bought At A Store	15.3%	14.3%	24.2% *	19.7%
Had someone buy for them	11.2%	17.6%	22%	19%
Other People	6.4%	12.5%	10.1%	10.2%
Other Way	14.9%	9.2%	8.1%	9.5%
Stole	20.1%	8.8%	2.8%	7.4%
Borrowed	4.8%	7.2%	8.2%	7.3%
Bought At A Vending Machine	5.6%	5.1%	3.6%	4.4%

* Significantly different from other groups (P < 0.01).
Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002.

Substance Abuse – Drugs

BACKGROUND

There is a vast array of illegal and prescription drugs available to adolescents. Examples of these substances are marijuana, inhalants, hallucinogens, LSD, Cocaine, Heroin, tranquilizers, steroids, and Ecstasy.

Symptoms of drug abuse may include difficulty in controlling substance-taking behavior, neglect of alternative pleasures or interests because of substance use, persistant substance use despite evidence of harmful consequences, depressive mood states consequent to heavy use, and drug-related impairment of cognitive functioning.[62] Drug use is also associated with crime, domestic violence, reduced school work productivity, injury, illness, disability, and death.[36]

Youth tend to use substances at a young age and exhibit sensation-seeking or "novelty-seeking" behaviors. They benefit from more intensive preventive interventions, including family therapy and parent training programs.[36]

The stigma attached to substance abuse compounds the problem. Hiding substance abuse, for example, can prevent persons from seeking and continuing treatment and from having a productive attitude toward treatment. Exacerbating the problem is the lack of available treatment for the number of persons seeking treatment for illicit drug use or problem alcohol use.[36]

HOW ARE WE DOING?

Table 25
Illicit Drug Use Among Adolescents

	Marijuana Use in the Past 30 Days	Recognize Marijuana Risk *Percent of adolescents who perceive great risk*
Santa Clara County 2002*		90.3
Percent of middle school students	3.9	
Percent of high school students	15.9	
California 2002**		92.3
Percent of middle school students	4.0	
Percent of high school students	18.2	
Healthy People 2010 Objective	0.7	80.0

*Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

**Source: California Healthy Kids Survey, California, 2002

Substance Abuse – Drugs continued

KEY FINDINGS

When asked how many times they had been high from drugs in a lifetime, 79% of students said they had never been high (Figure 81). Approximately 13% said they had been high three or more times in their lifetime.

In general, more males than females engaged in drug use (marijuana and inhalants). Native Americans/Alaskan Native students had the highest proportions of drug use – their reported use was significantly greater than White students. Asian/PI students reported the lowest proportions of drug use and related behavior. More students reporting using drugs as they moved into higher grade levels (Figure 81).

Overall, 22% of respondents reported using marijuana in their lifetime. Significantly more males in 7th, 9th and 11th grade reported this than their female counterparts (Figure 82).

Nearly 12% of the students reported using marijuana in the last 30 days (Figure 83). Only White and Asian/PI male students reported significantly more use of marijuana in the last thirty days than their female counterparts (data not shown). Significantly more 11th grade males reported using marijuana in the last thirty days than females.

When asked at what age they first used marijuana, 79% said they had never used marijuana and about 8% said before age 13 (Figure 84). The highest proportion of marijuana use before age 13 was among Hispanics. Significantly more males reported use of marijuana before age 13 than females (data not shown).

Overall, 46% of the students surveyed perceived getting marijuana as easy or very easy (Figure 85). The perception of how easy it is to obtain marijuana increased as grade level increased. The perception of difficulty in getting marijuana decreased as grade levels increased.

A total of 11% of students surveyed reported using inhalants (Figure 86). There was no significant difference between males and females. Hispanics reported using inhalants more than other race/ethnicity. Significantly more females than males in 9th grade reported using inhalants in their lifetime. For 11th graders, more males than females reported this behavior (data not shown). Overall 4% of respondents reported using inhalants in the last 30 days (Figure 87). Seventh graders reported the highest current use of inhalants.

Substance Abuse – Drugs continued

Figure 81

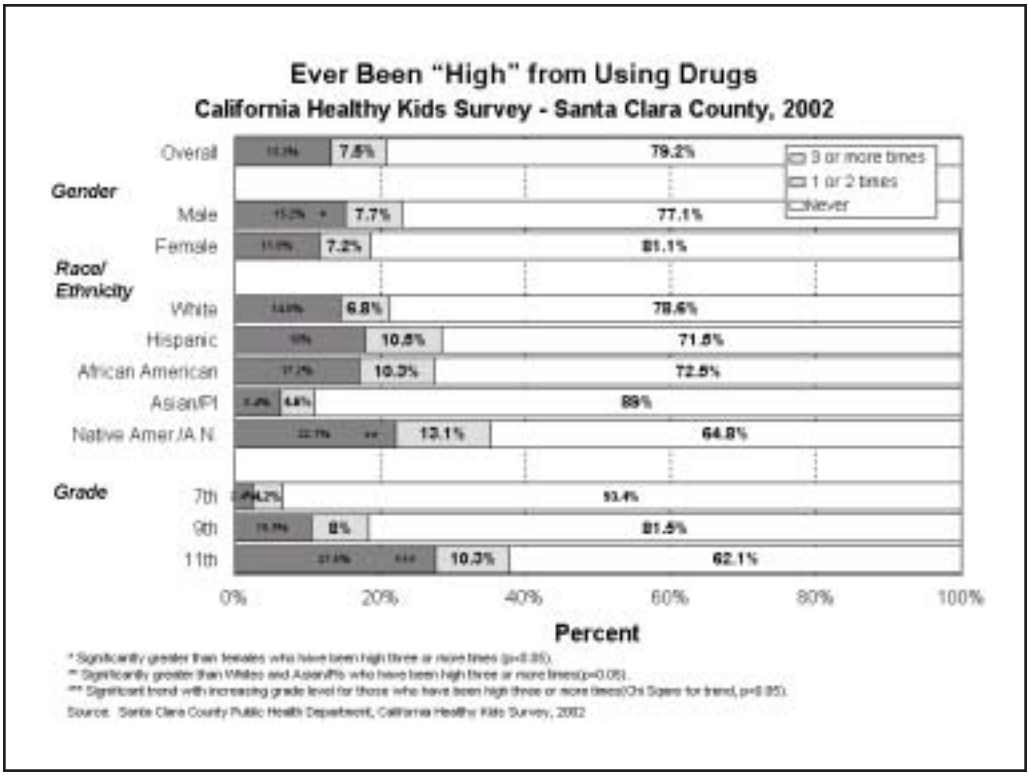
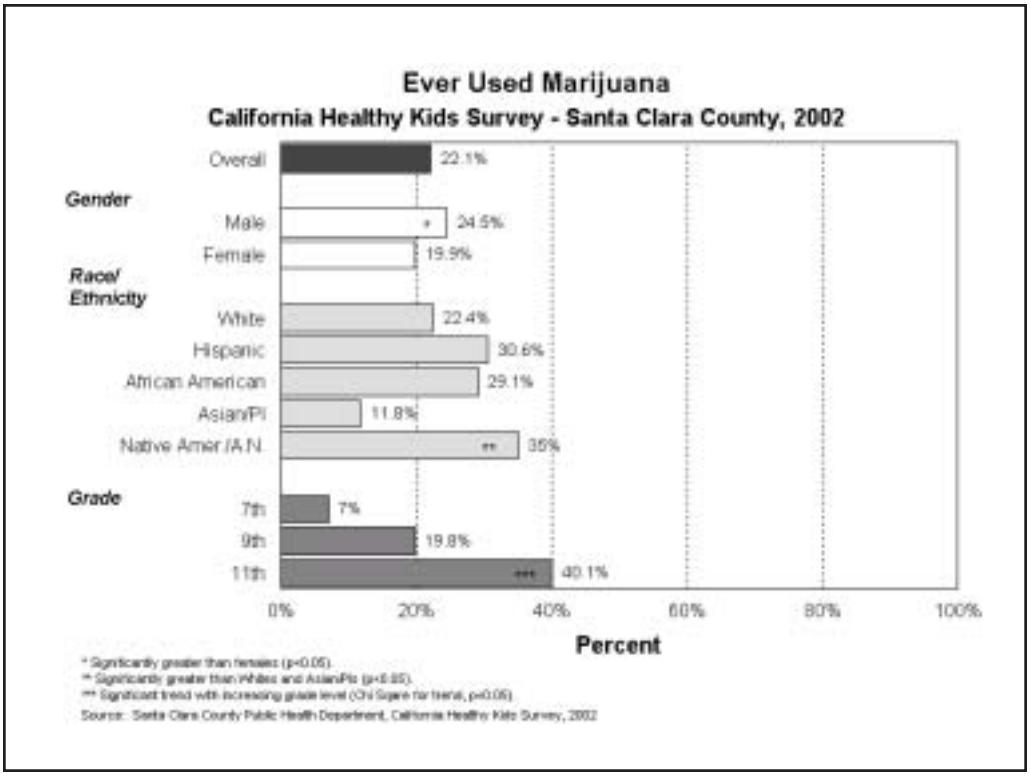


Figure 82



Substance Abuse – Drugs continued

Figure 83

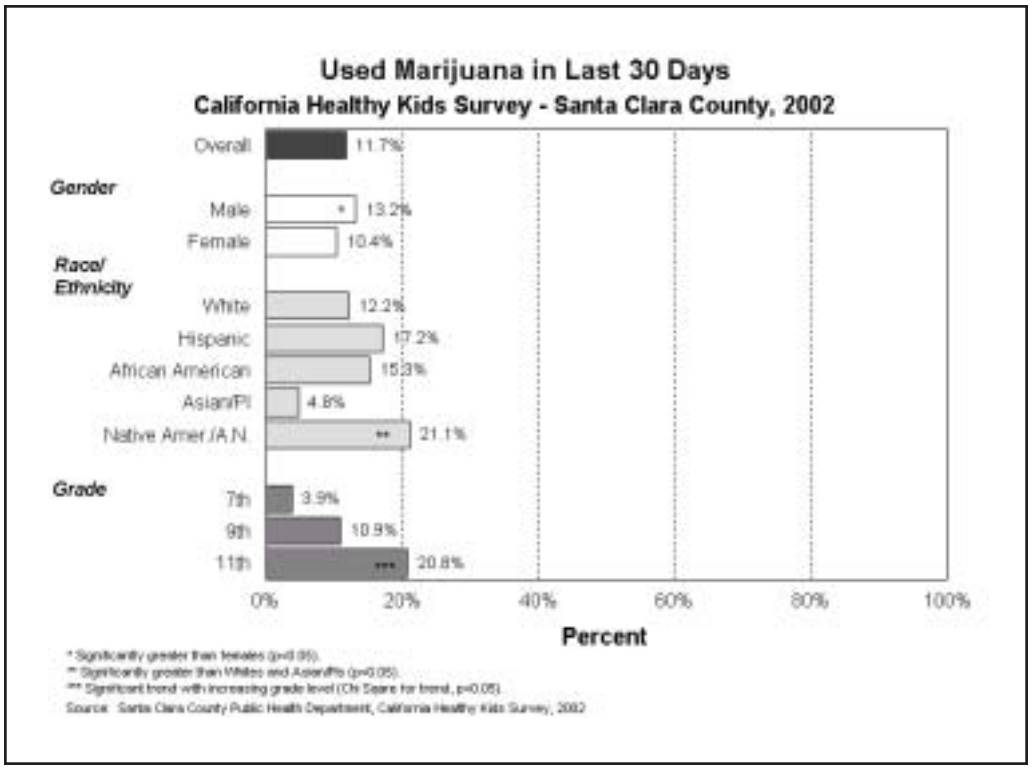
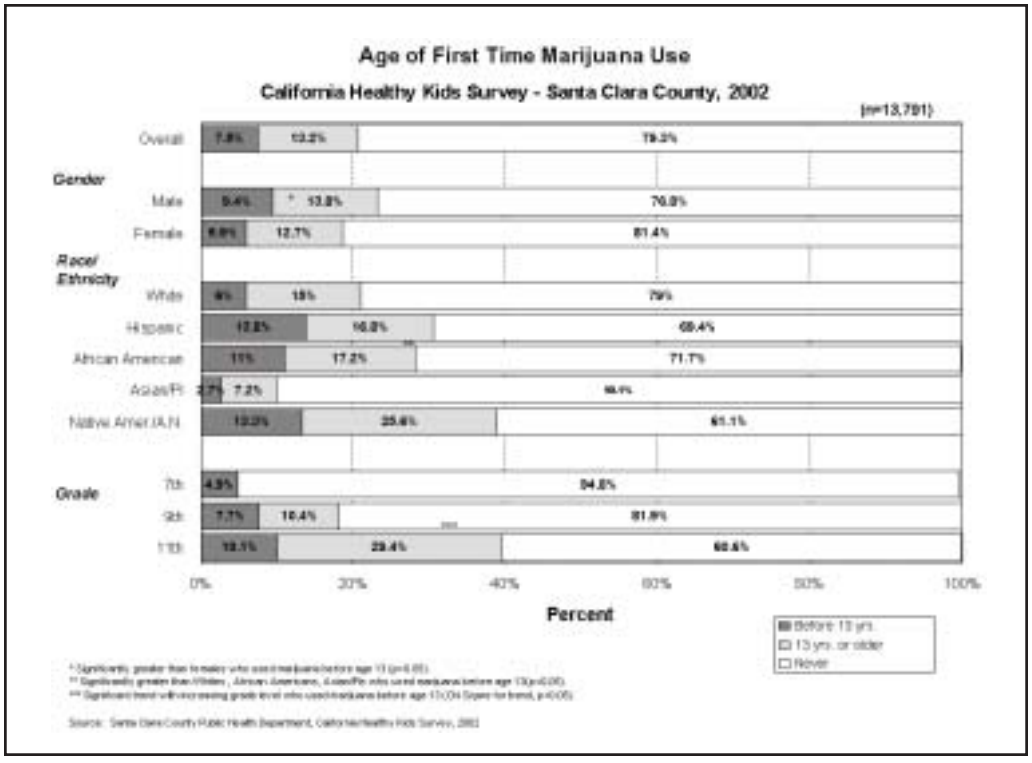


Figure 84



Substance Abuse – Drugs continued

Figure 85

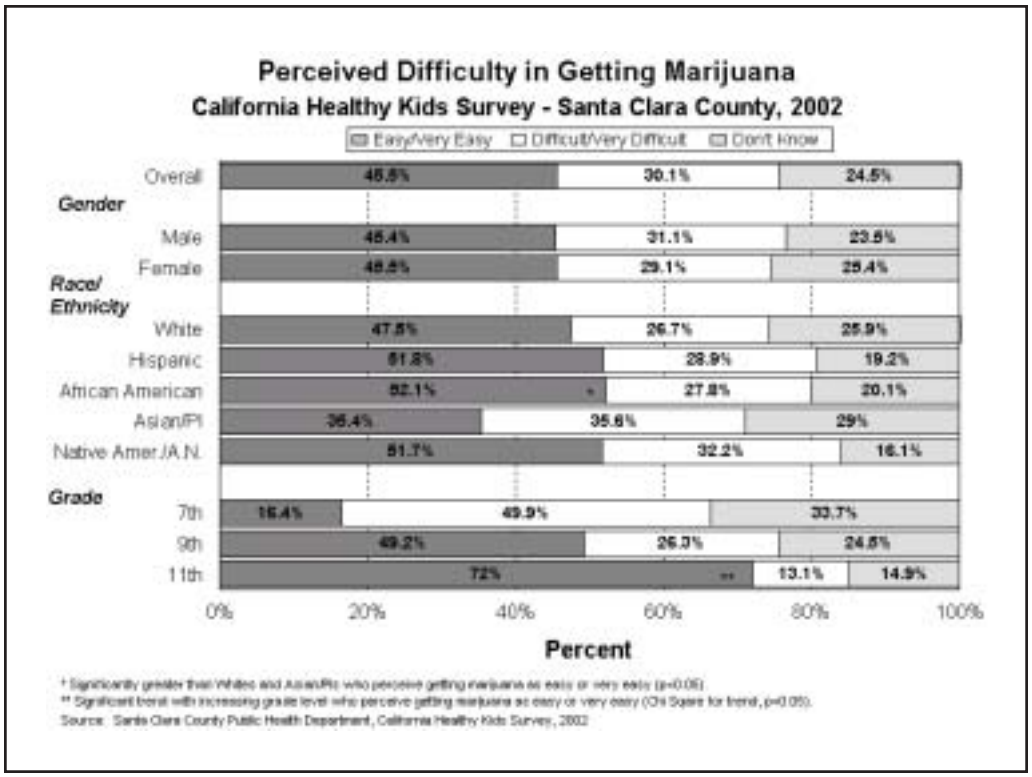
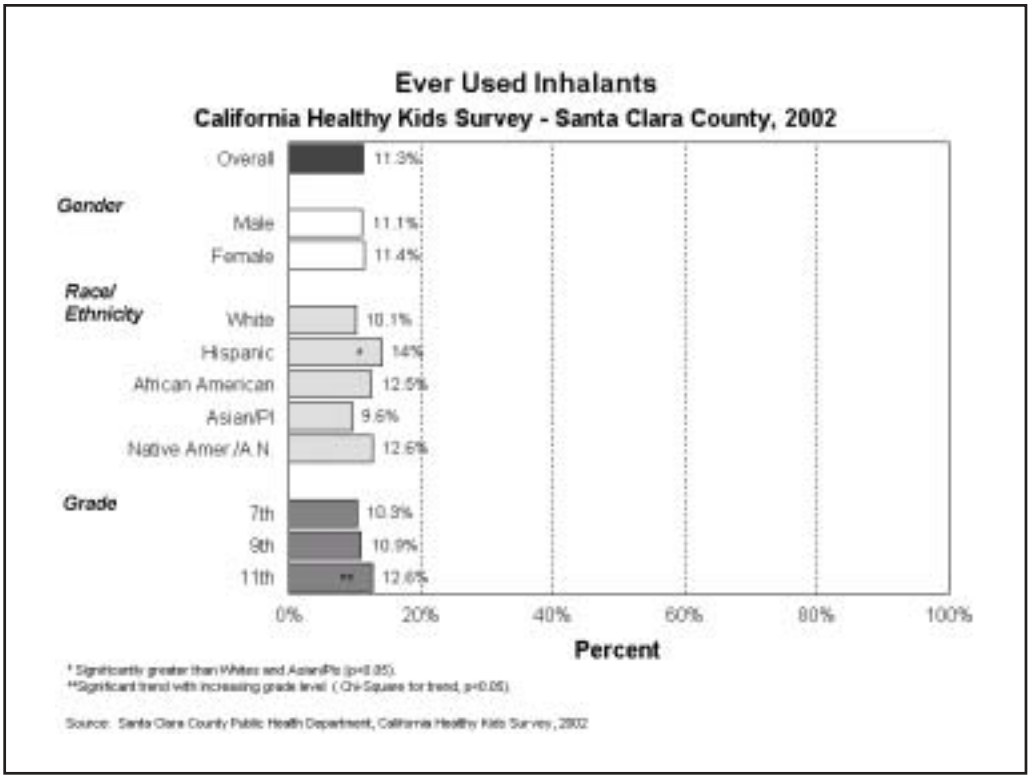
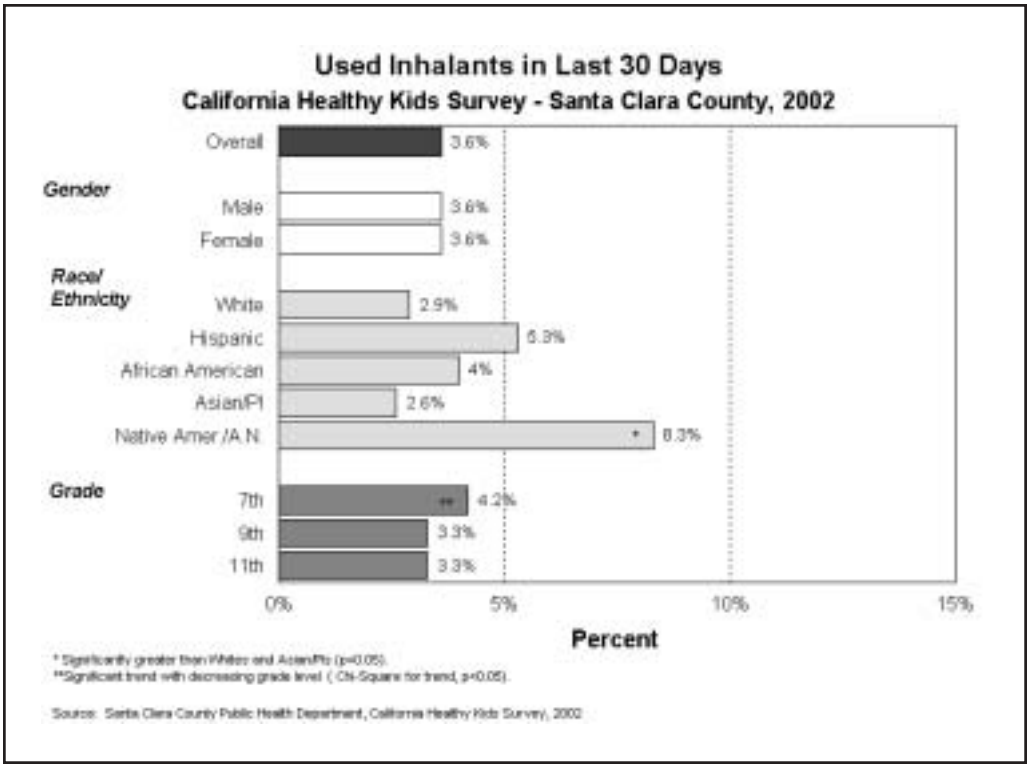


Figure 86



Substance Abuse – Drugs continued

Figure 87



Substance Abuse – Alcohol

Alcohol is the number one drug of choice among the nation's youth.[63] It is socially, economically, and commercially available to minors, who obtain it primarily from parents, older peers, and merchants who sell to older minors.[64] Over 40% of individuals who begin drinking before age 13 will develop alcohol abuse or alcohol dependency at some point in their lives. Young persons who begin drinking before age 13 are four times more likely to develop alcohol dependence and twice as likely to develop alcohol abuse as those who begin drinking at age 21.[65] Nationally, approximately 21% of 8th graders, 41% of 9th graders, 39% of 10th graders, and 50% of 12th graders reported having consumed alcohol during the past month. Evidence suggests that alcohol use by peers is a strong predictor of adolescent use of alcohol.[66]

Table 26
Alcohol Consumption

	Never Drank Alcohol *Percent of high school students*	Binge Drinking*** *Percent of middle and high school students*	Perceived Harm from Frequent Alcohol Use *Percent of middle and high school students*
Santa Clara County 2002*	38.0	10.6	91.6
California 2001**	43.2	14.0	95.0
Healthy People 2010 Objective	29.0****	2.0	NA

*Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

**Source: California Healthy Kids Survey, 2001

***Note: Refers to having 5 or more alcoholic beverages in a single occasion once or twice a week in the past month.

****For high school seniors only

Substance Abuse – Alcohol continued

KEY FINDINGS

Overall, 39% of students in middle and high school have had at least one drink of alcohol during their lifetime (Figure 88).

In Santa Clara County, 22% of students surveyed reported that they have had at least one drink in the last 30 days prior to the survey, and about 20% reported having had their first drink before age 13.

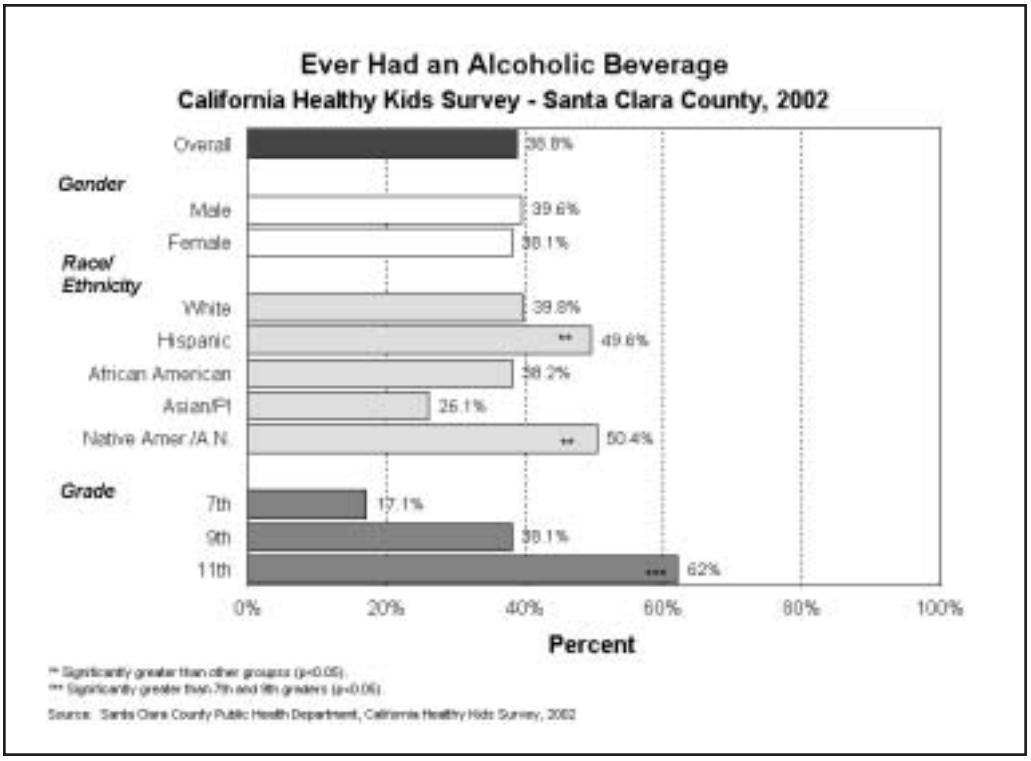
A significantly higher proportion of Hispanic and Native American students reported having had a drink at least once in their lifetime compared to other ethnic groups (Figure 88). A higher proportion of Hispanic and Native American students also reported being current drinkers and binge drinkers as compared to students in other ethnic groups (Figures 89, 90). Thirty percent of Hispanics reported they had their first drink before age 13.

Overall, 8% of the students surveyed perceived no harm in drinking alcohol (Figure 91). This percentage was higher among male students (10%) compared to female students (7%). A significantly higher proportion of Hispanic students did not perceive any harm in drinking alcohol compared to students in other ethnic groups. Over half of all respondents did not perceive any difficulty of getting alcohol. A higher proportion of students in higher grades perceived no difficulty in getting alcohol.

Almost 30% of all students had been drunk or ridden in a vehicle with a drunk driver at least once in their lifetime (Figure 92). A higher proportion of female students (30%) reported to have engaged in this behavior compared to male students (28%). Almost 40% of Hispanic students, the largest proportion compared to students in other eth–nic groups, had been drunk or ridden with a drunk driver.

Among the students who have ever had a drink, almost 55% reported that they had been drunk or sick after drinking. The proportion of students who were drunk or sick after drinking was highest among Whites, followed by Hispanics, Native Americans, African Americans, and Asians/PIs (Figure 93).

Figure 88



Substance Abuse – Alcohol continued

Figure 89

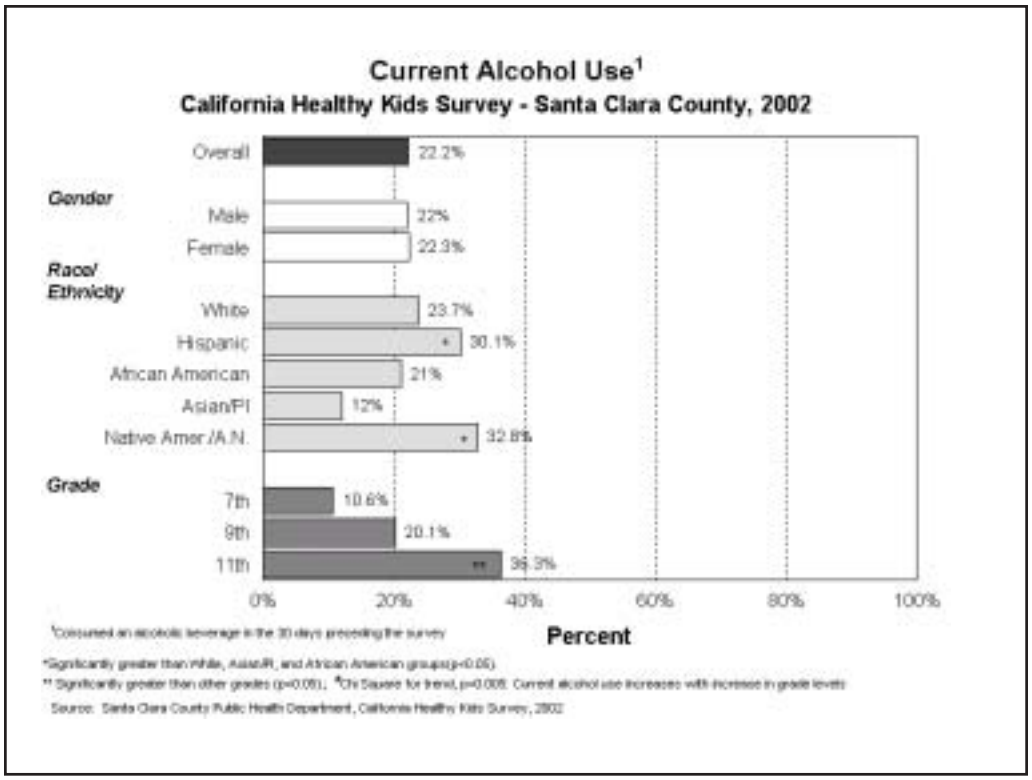
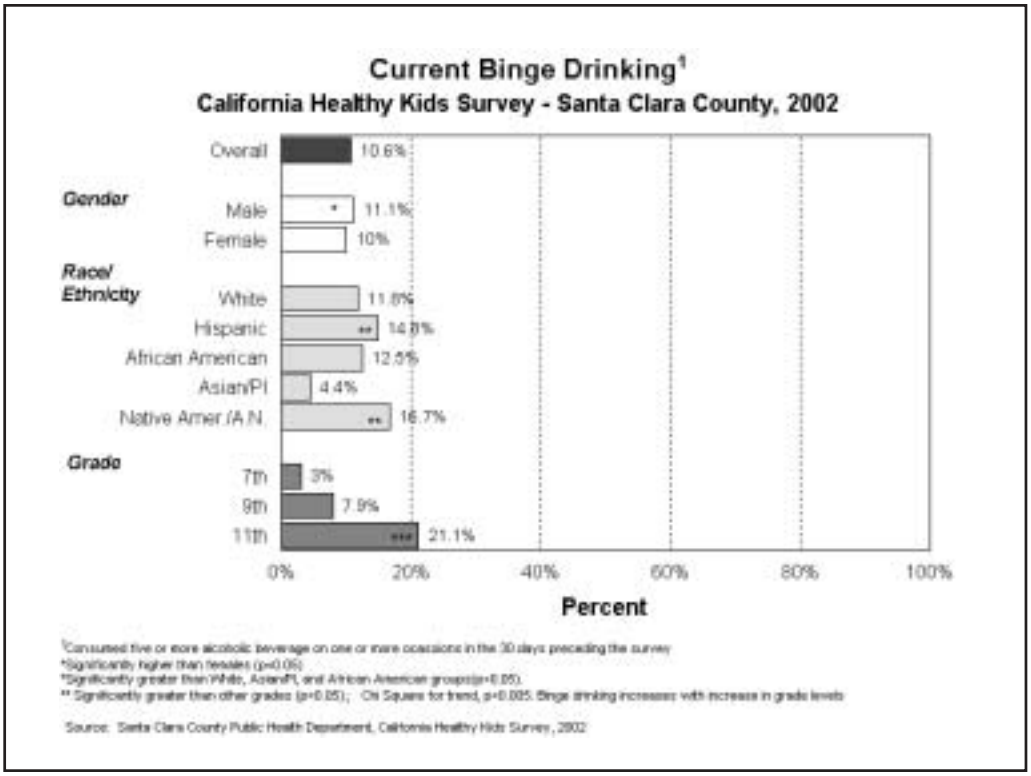


Figure 90



Substance Abuse – Alcohol continued

Figure 91

Perception of Alcohol Use and Obtaining Alcohol
California Healthy Kids Survey - Santa Clara County, 2002

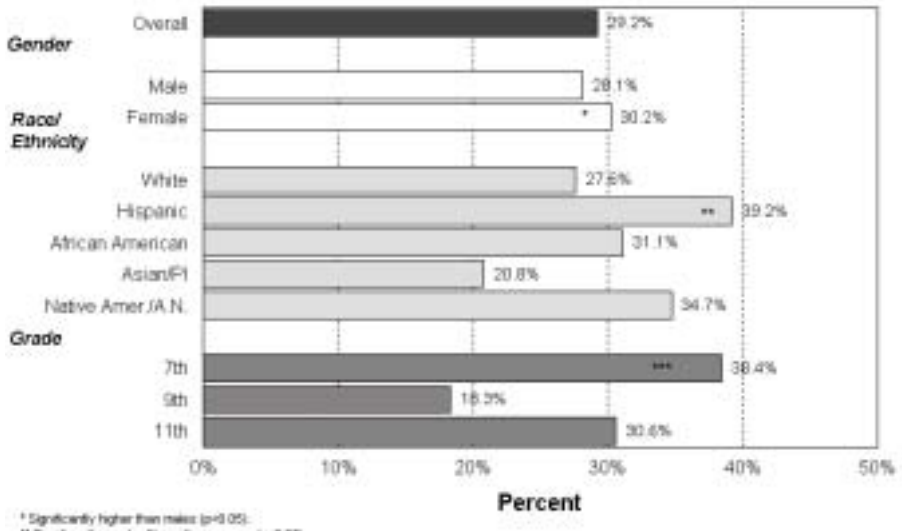
		Perceived "No/Minimal Harm" of Alcohol Use	*Perceived "No Difficulty" In Obtaining Alcohol*
	Overall	8.4%	57.1%
Gender			
	Male	9.8% *	54.6%
	Female	7%	59.4% *
Race/ Ethnicity			
	White	6.7%	60.8% **
	Hispanic	11.7% **	56.4%
	African American	7.4%	58.8% **
	Asian/PI	7.1%	53.2%
	Native Am/A.N.	10.9%	54.2%
Grade			
	7th	7.8%	30.9%
	8th	8.4%	63.6%
	11th	9.1% ***	77.9% ***

* Significantly higher (p<0.05).
** Significantly greater than other groups (p<0.05).
*** Significantly greater than other grades (p<0.05); Chi Square for trend, p<0.05

Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

Figure 92

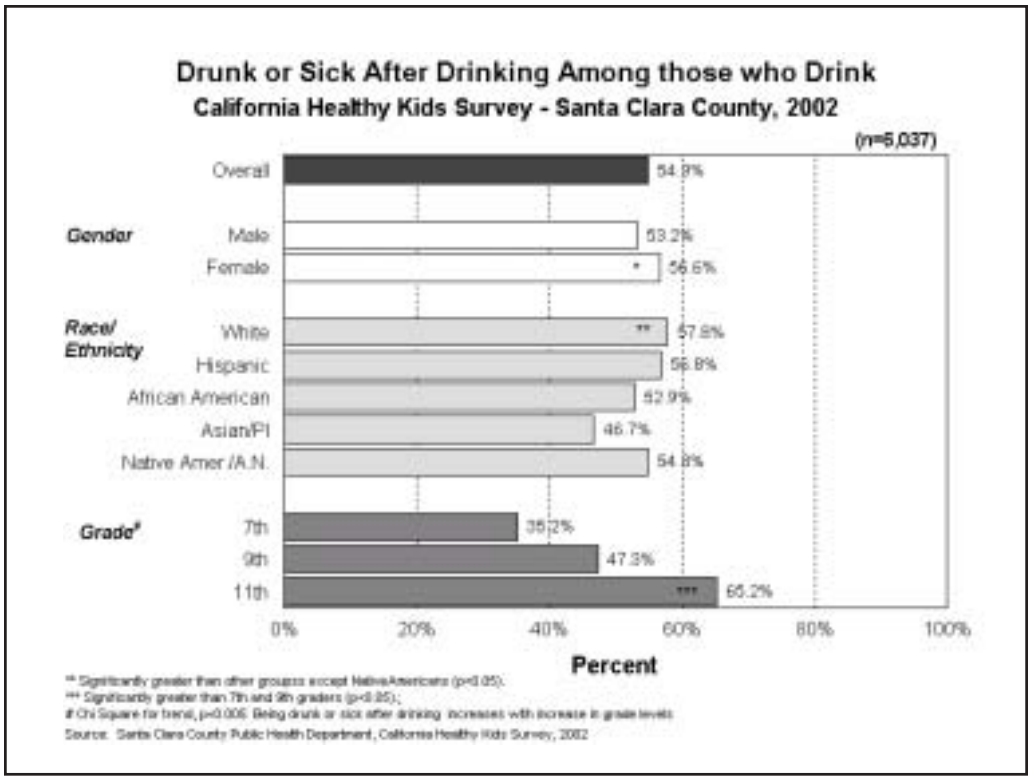
Ever Driving while Drunk or Ridden with a Drunk Driver
California Healthy Kids Survey - Santa Clara County, 2002



* Significantly higher than males (p<0.05).
** Significantly greater than other groups (p<0.05)
*** Significantly greater than other grades (p<0.05)
Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

Substance Abuse – Alcohol continued

Figure 93



Teen Births

BACKGROUND

Early childbearing has consequences for both the mother and child. Teenage parents and their children often face challenges such as poverty, lower education levels, and poor health. Teenage pregnancy is correlated with poor school performance and alcohol or drugs use. Adolescents whose parents have low levels of education, are economically poor, are not married, and were teen parents themselves are at higher risk for teen pregnancy.[61]

HOW ARE WE DOING?

Table 27
Teen Birth Rate
Number of Births per 1,000 Females
Among 15 to 17 Year Olds

Santa Clara County 2000*	17.9
California 2000**	28.6
United States**	27.4

*Source: California Department of Health Services, Maternal & Child Health Branch, 2000.
**Ventura SJ, Mathews TJ, Hamilton BE, Teenage birth in the United States=Trends, 1991-2000, an update. National Vital Statistics Reports; vol. 50 no. 9. Hyattsville, MD: national Center for Health Statistics 2002

KEY FINDINGS

The teen birth rate in Santa Clara County steadily decreased between 1996 and 2000 for all age groups between 12 and 19 years old (Figure 94). Birth rates declined substantially among Whites, African American and Asians/PIs (Figures 95, 96). The teen birth rate among Hispanics was about 49 births per 1,000 females and has yet to achieve the Healthy People 2010 Objective. Birth rates for the Native American/Alaskan Native population fluctuate widely because of the small number of births.

The education level of adolescent mothers age 12 to 14 increased from 1996 to 2000 (Figure 97). In 1996, 69% had completed 8th grade, while in 2000, 81% had completed 8th grade.

In the survey of Santa Clara County students, about 3% replied to having been pregnant or gotten someone else pregnant at least once (Figure 98). There were, however, disparities between different ethnic groups. Seven percent of Hispanic students and 8% of African American students indicated that they had been pregnant or gotten someone pregnant at least once.

In 1996, nearly 76% of mothers age 12 to 14 had medical insurance, but in 2000, only 67% had medical insurance (Figure 99). Twenty percent of mothers age 12 to 14 used private insurance as a source of payment in 1996, but nearly 29% used private insurance in 2000.

Teen Births continued

Figure 94

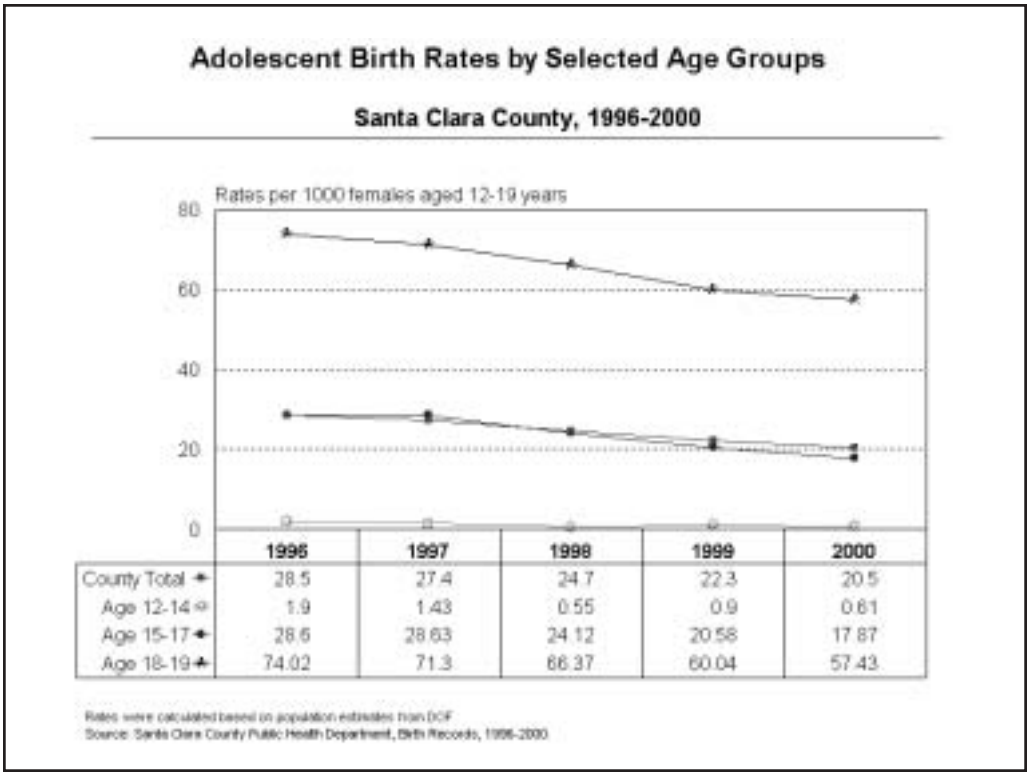
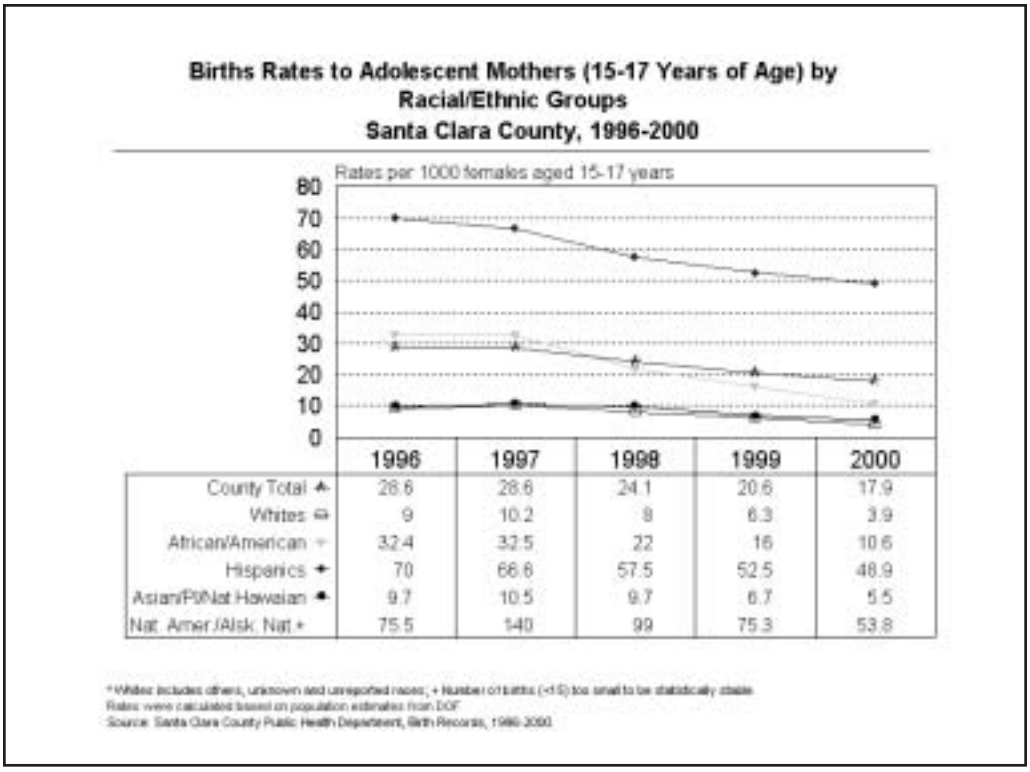


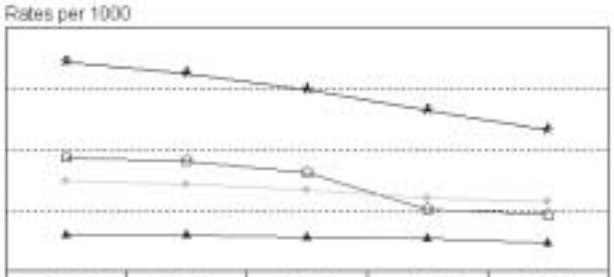
Figure 95



Teen Births continued

Figure 96

Births Rates to Adolescent Mothers (18-19 Years of Age) by Racial/Ethnic Groups
Santa Clara County, 1996-2000



	1996	1997	1998	1999	2000
County Total +	74	71.3	66.4	60	57.4
Whites *	30.2	30	28	27	23.3
African/American	92.7	90.5	80.4	50.9	46.3
Hispanics *	171.3	161.8	148.5	131.8	115.5
Asian/PI	28.2	26.9	26.6	26.6	22.5
Nat. Amer./Alsk. Nat.+	122	117.6	180.3	152.5	176.5

*Whites includes others, unknown and unreported races; + Number of births (<15)too small to be statistically stable
Rates were calculated based on population estimates from DOF
Source: Santa Clara County Public Health Department, Birth Records, 1996-2000

Figure 97

Adolescent Births (%) by Education Level of Mother
Santa Clara County 1996 & 2000

Year	Mother's age group	County Total	Grade 1-8	Grade 9-11	Grade 12	Grade 13-15	Grade 16-17	Unknown
2000	12-14	21	17 (81%)	4 (19%)	0	0	0	0
	15-17	581	82 (14.1%)	444 (76.4%)	39 (6.7%)	0	0	16 (2.8%)
	18-19	1191	153 (12.8%)	439 (36.9%)	465 (39.0%)	100 (8.4%)	2 (0.2%)	32 (2.7%)
1996	12-14	58	40 (69%)	17 (29.3%)	0	0	0	1 (1.7%)
	15-17	818	123 (15%)	608 (74.3%)	76 (9.3%)	4 (0.5%)	1 (0.1%)	6 (0.7%)
	18-19	1319	166 (12.6%)	470 (35.6%)	554 (42%)	116 (8.7%)	1 (0.1%)	12 (0.9%)

Source: Santa Clara County Public Health Department, Birth Records, 1996-2000.

Teen Births continued

Figure 98

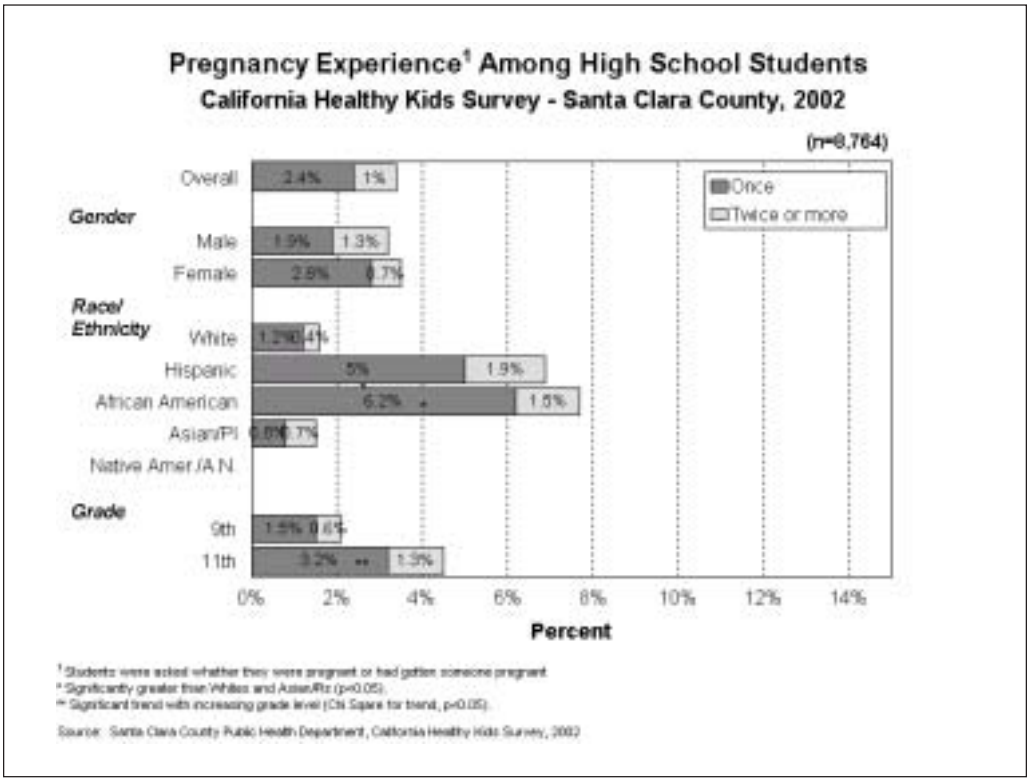


Figure 99

Mother's Age by Source of Payment
Santa Clara County 1996 & 2000

Year	Mother's age group	Medi-Cal	Private	No Insurance
2000	12-14	14 (66.7%)	6 (28.6%)	1 (4.8%)
	15-17	385 (62.8%)	215 (37.0%)	1 (0.2%)
	18-19	693 (58.2%)	497 (41.7%)	0
1996	12-14	44 (75.9%)	13 (20.7%)	1 (1.7%)
	15-17	497 (60.8%)	313 (38.3%)	5 (0.6%)
	18-19	975 (68.3%)	411 (31.2%)	4 (0.3%)

Source: Santa Clara County Public Health Department, Birth Records, 1996-2000

Sexual Behavior

In the United States, 46% of high school students[68] and 80% of college students age 18 to 24 have had sex.[69] A young person's decision on whether to have sexual intercourse may be influenced by many factors, including socioeconomic status, ethnicity, family structure, educational aspirations, age, and life experiences. Unprotected sexual intercourse places young persons at risk for human immunodeficiency virus (HIV) infection, other sexually transmitted diseases (STDs), and unintended pregnancy. Responsible sexual behavior among adolescents is one of the ten leading health indicators of the national Healthy People 2010 Objectives.[36]

Table 28
Percent of Sexually Active 15-17 Year Olds
Who Use Condoms

	Males	Females
Santa Clara County 2002	60	50
California	NA	NA
Healthy People 2010 Objective	83	75

Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

Table 29
Sexual Behavior Indicators
Percent Among 15-17 Year Olds

	Condom Use	Have Had Sexual Intercourse	Currently Sexually Active	Used Alcohol or Drugs Before Last Sexual Intercourse	Abstain or Use Condoms
Santa Clara County 2002	61.9	24.8	17.5	23.6	85.0
California (not available)	NA	NA	NA	NA	NA
2001 National YRBS (High School)	57.9	45.6	33.4	25.6	95.0

Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

Sexual Behavior continued

KEY FINDINGS

About 20% of all Santa Clara County students surveyed have had sexual intercourse at least once (Figure 100). This prevalence was higher among males compared to females, and higher among Hispanics, African Americans, and Native Americans compared to Whites and Asians/PIs.

Early initiation of sexual intercourse and unprotected sex are direct factors that affect the health status of teenagers. About 5% became sexually active before age 13. A higher proportion of males than females initiated sexual activity before age 13 (Figure 101). Overall, 14% of all students initiated their sexual activity at or after age 13. Overall, 16% of sexually active students did not use any birth control method (Figure 102). Over half of the respondents used condoms and 13% used birth control pills. Hispanic, Asian/PI, and African American students had a higher proportion of response "No method used" compared to White students. Over 60% of students who had ever been sexually active used a condom during their last sexual encounter (Figure 103).

Of high-school students who were sexually active, 12% reported having one partner during the past three months, whereas about 6% reported having two or more partners during the three months preceding the survey (Figure 104). More males than females reported having two or more current partners. Hispanics and African-Americans also had higher proportions of having two or more partners than the other ethnic groups. There was a higher proportion of students in 11th grade who had two or more sexual partners in the three months preceding the survey than students in 9th grade.

Overall, 24% of the students had used either drugs or alcohol prior to sex (Figure 105). About 30% of males and 19% of females had engaged in this risk behavior.

About 3% of students reported having been pregnant or gotten someone else pregnant at least once (Figure 106). There are, however, disparities between different ethnic groups. Seven percent of Hispanic students and 8% of African American students indicated that they had been pregnant or gotten someone pregnant at least once. For more information about teen births, please refer to the section, "Teen Births."

Over 70% of the students reported there was no likelihood of being sexually active in the following year. About 17% of the students reported a likelihood of being sexually active in the following year, and 13% of the students reported they were not sure (Figure 107).

Among all students, 6% reported to have been forced to have sex (Figure 108). A higher proportion of female students were forced to have sex compared to male students. Among those who ever had sex, 18% reported that they were forced to have sex (Figure 109). One-fourth of all female students who had sex reported that they were forced to have sex. Females reported being forced to have sex two times more than males. The differences between male and female students were greater among African American students and Hispanic students.

In Santa Clara County, chlamydia and gonorrhea infections among youth continue to increase (see Communicable Diseases section). Although Santa Clara County does not have a tremendous burden of AIDS among youth, rates of actual HIV infection are unknown at this time.

Sexual Behavior continued

Figure 100

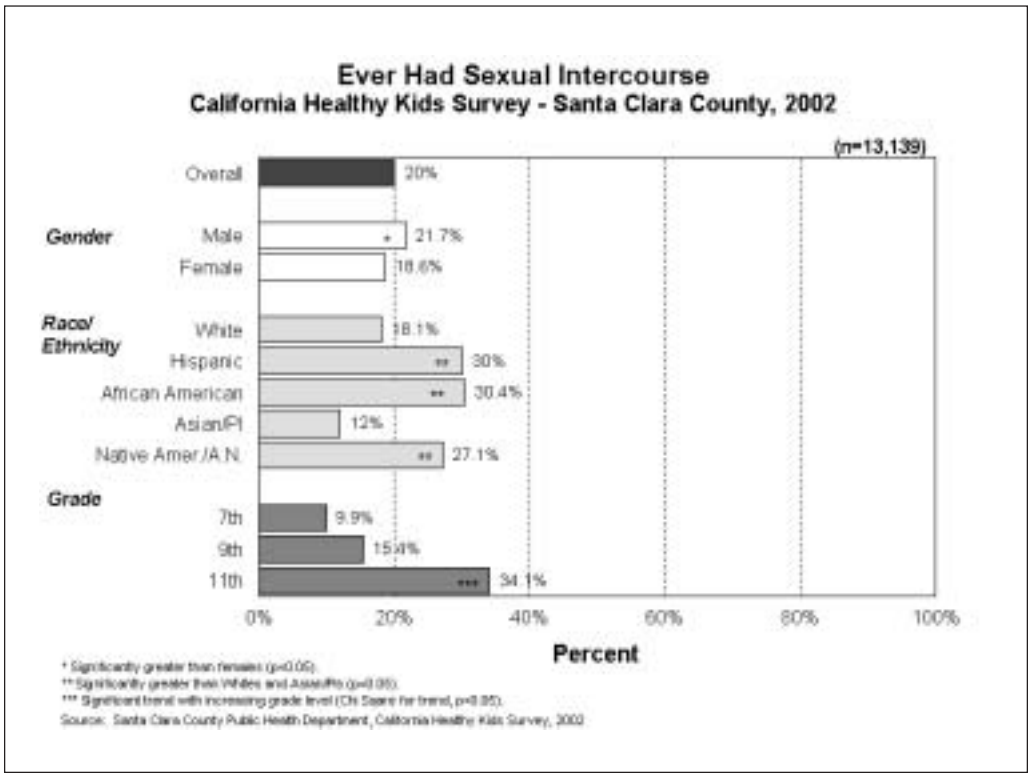
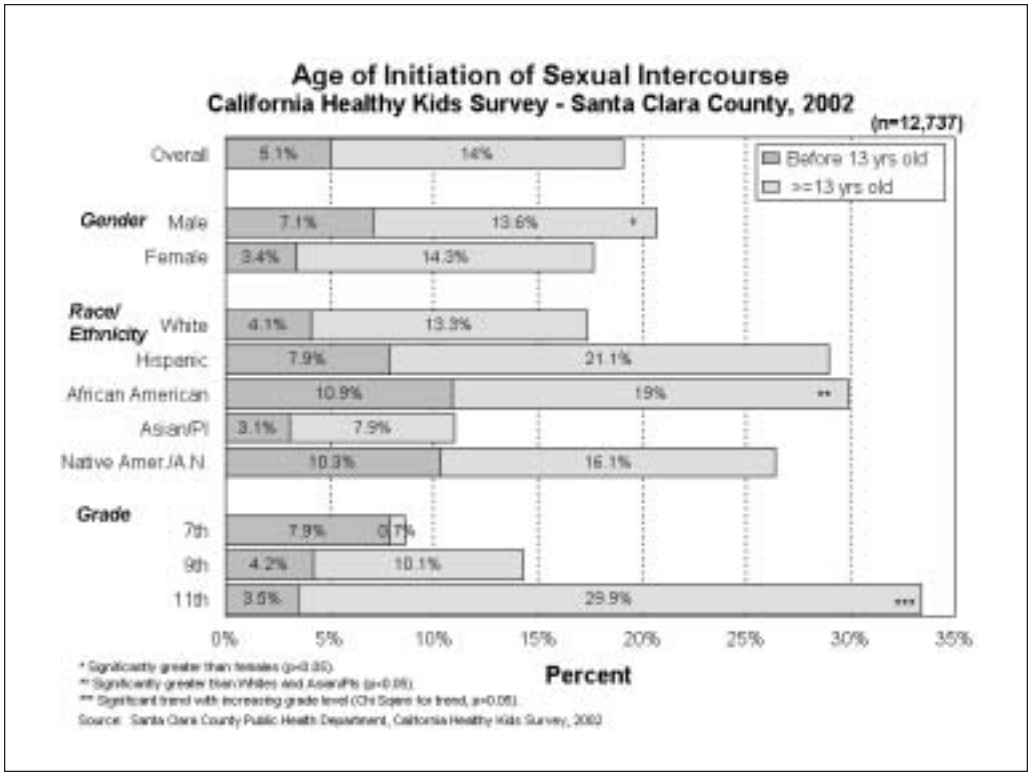


Figure 101



Sexual Behavior continued

Figure 102

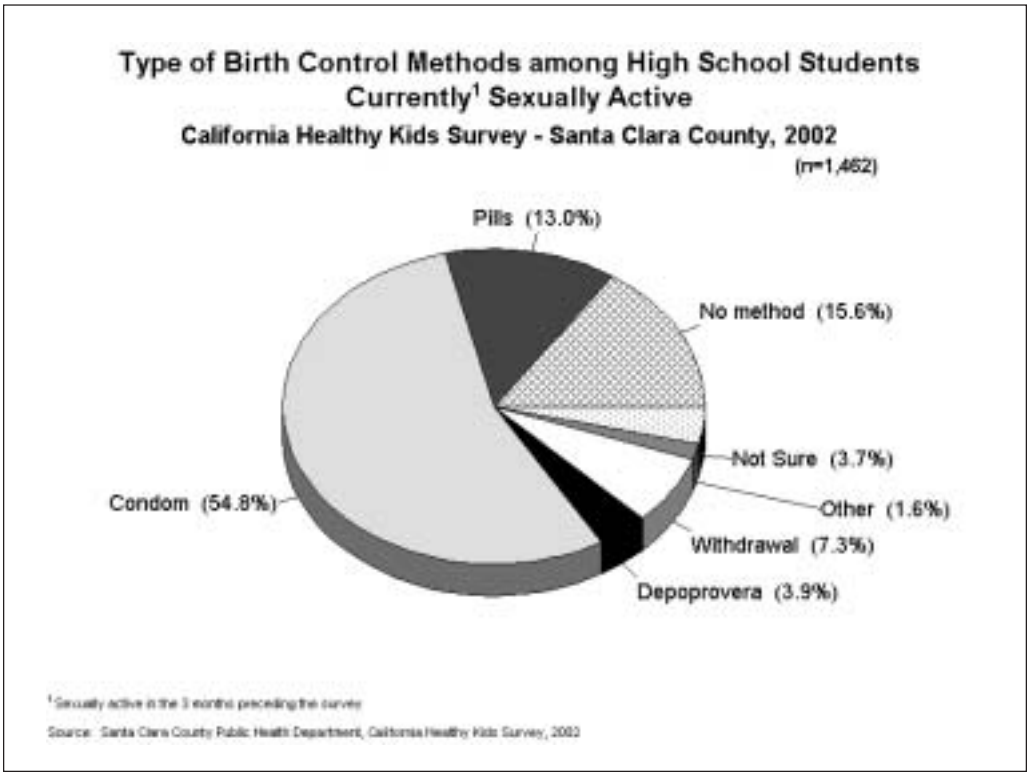
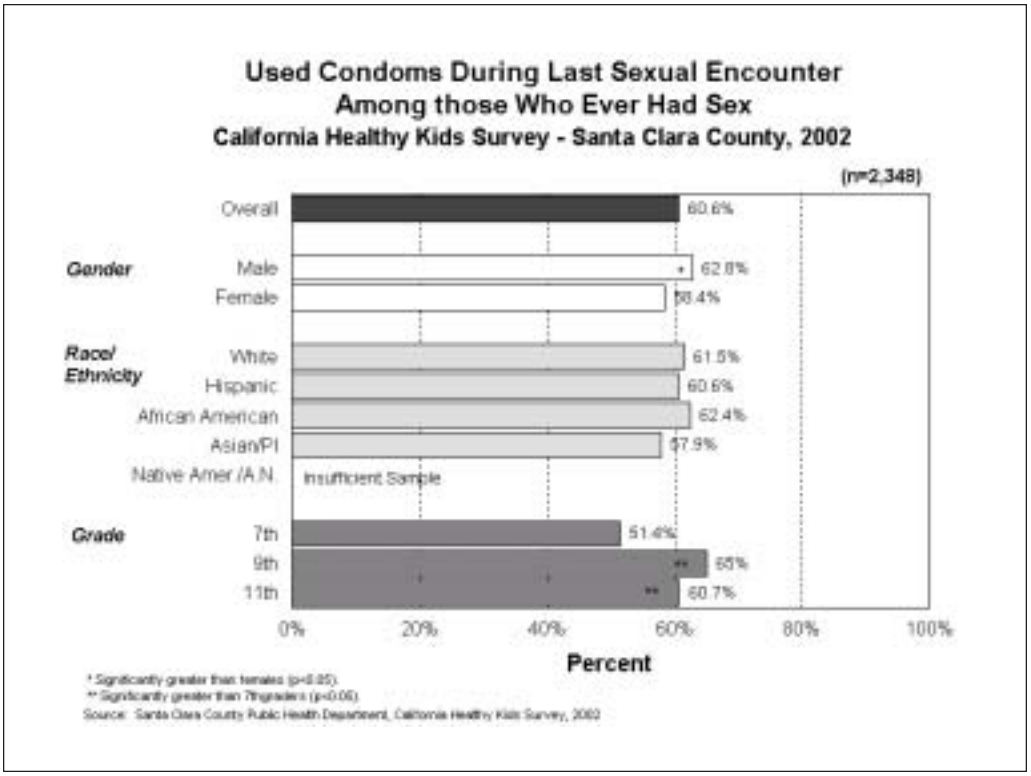


Figure 103



Sexual Behavior continued

Figure 104

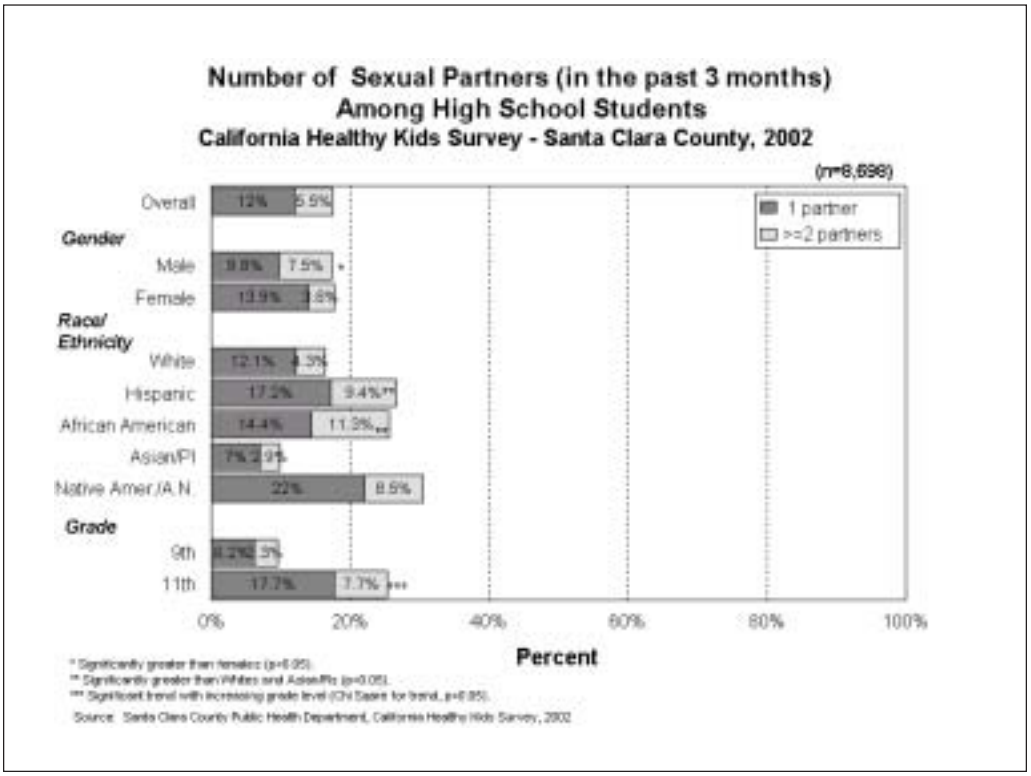
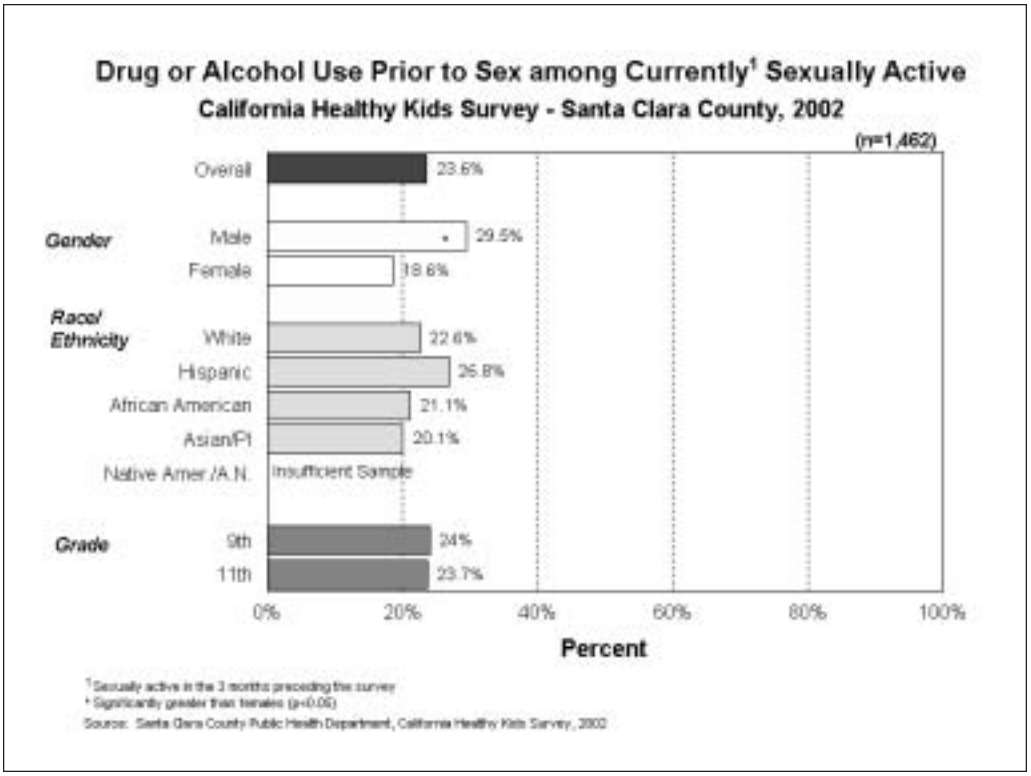


Figure 105



Sexual Behavior continued

Figure 106

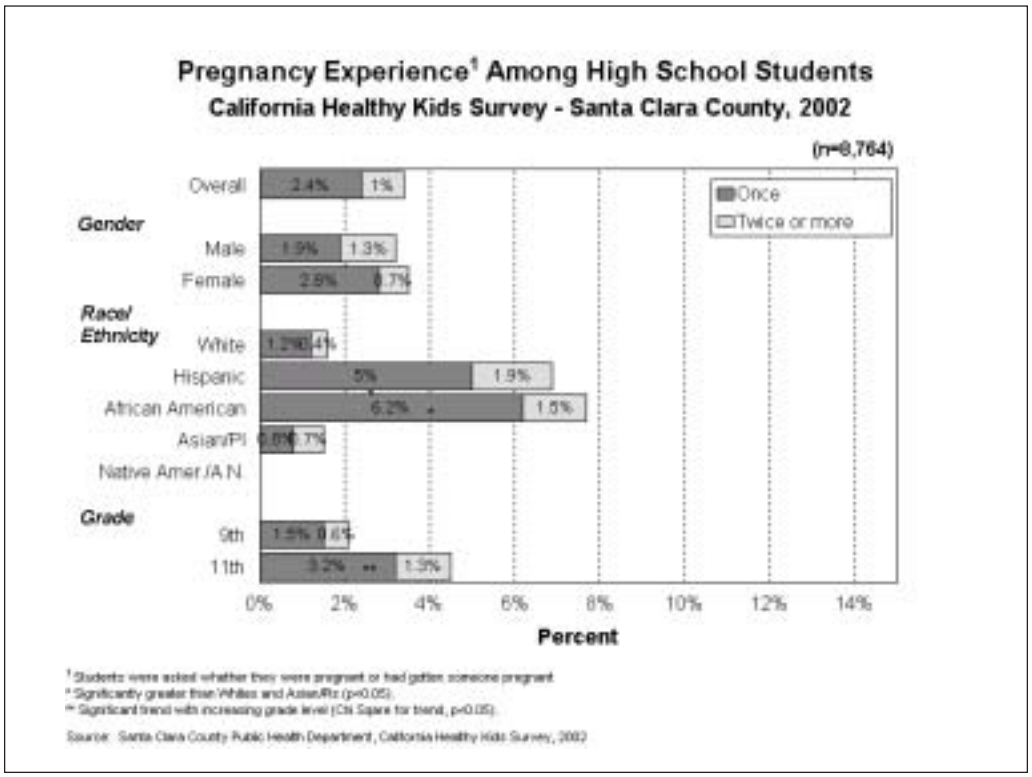
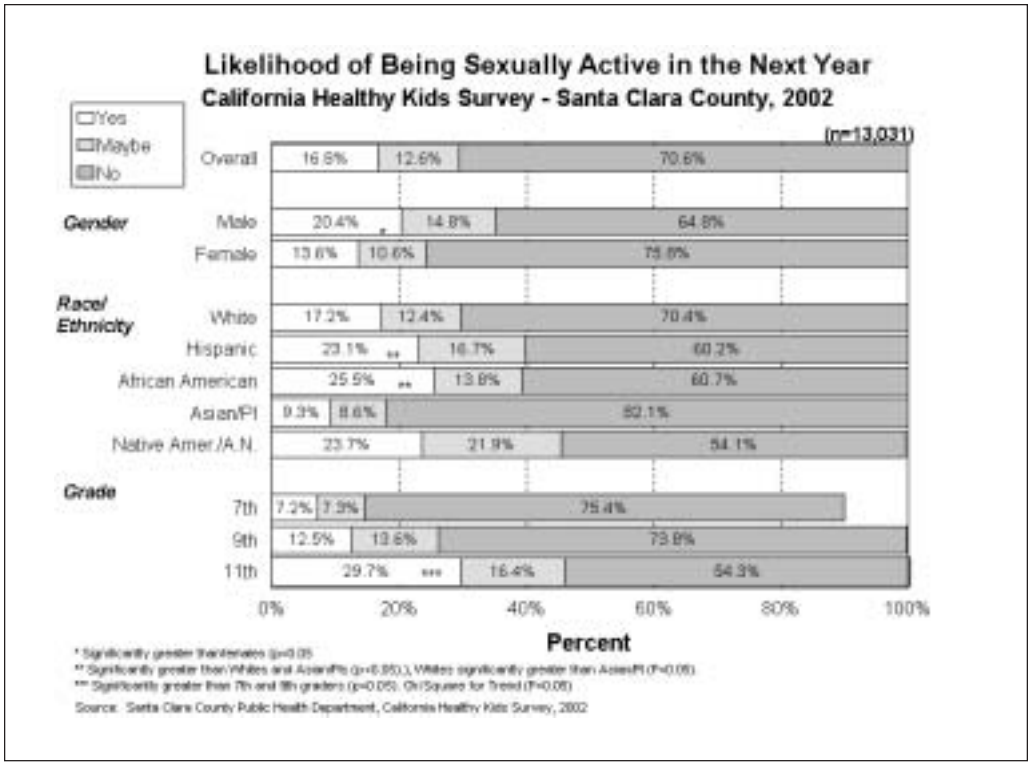


Figure 107



Sexual Behavior continued

Figure 108

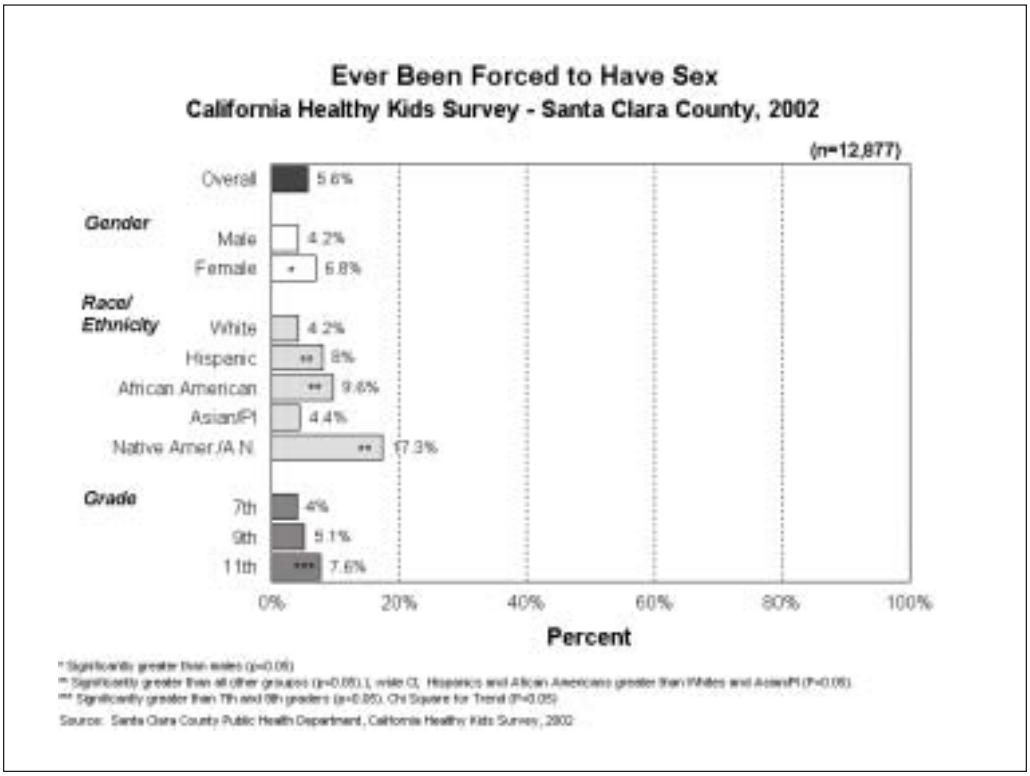
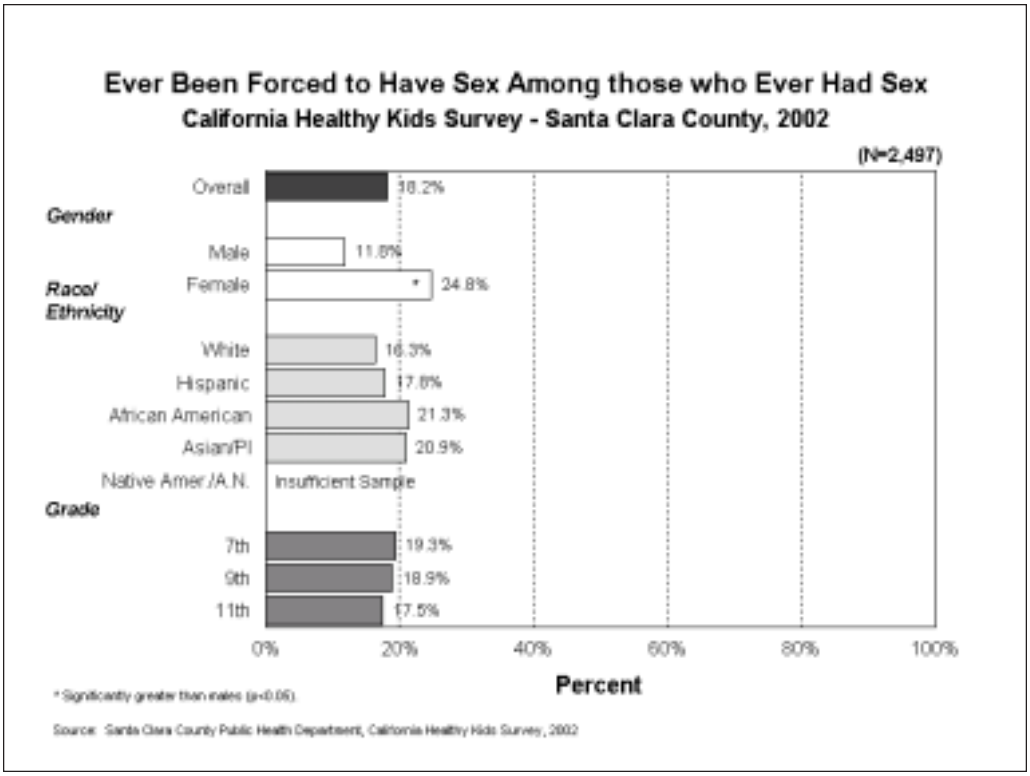


Figure 109



Emotional Health

A child's emotional health is influenced by several factors including their own physical, psychological, mental, and social health. Children and teenagers can struggle with pressures from friends, parents, school, work, and sports. Emotional problems may be expressed in prolonged or repeated bouts of anger, fear or phobias, panic, anxiety, sadness, depression, obsessive-compulsive behavior, difficulties in communication, or feelings of grief and loneliness.[70] The most serious consequence of poor emotional health is suicide.

Suicide

Persons under age 25 accounted for 15% of all suicides in 2000. For young people 15 to 24 years old, suicide is the third leading cause of death in the nation.[71] The risk of suicide has been shown to increase conditions of low self-esteem, broken relationships, family stress, and drug and alcohol abuse, problems with which adolescents struggle. Suicidal behavior can stem from feelings of depression. However, depression can remain hidden. Often there are warning signs before suicide attempts. Several emotional and behavioral changes can be warning signs: hopelessness, powerlessness, feelings of worth–lessness, social isolation, declining performance in school, declining interest in friends and hobbies, and personality changes. By identifying these risk factors, events may be prevented by appropriate intervention.[72]

Table 30
Percent of High School Students Who Had Seriously Considered Attempting Suicide in the Past 12 Months

Santa Clara County 2002*	19.9
U.S. 2001**	19.0

*Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

** Source: National Youth Risk Behavior Survey, 2001

Suicide continued

KEY FINDINGS

According to the year 2000 County Public Health Department's death records, there were a total of seven suicides among Santa Clara County residents who were less than 20 years of age, three of which were between 13 and 15 years old.

Among Santa Clara County students, 21% reported that they *seriously thought of committing suicide in the past* (Figure 110). Female high school students (25%) reported that they had had thoughts of committing suicide significantly more often than males (15%).

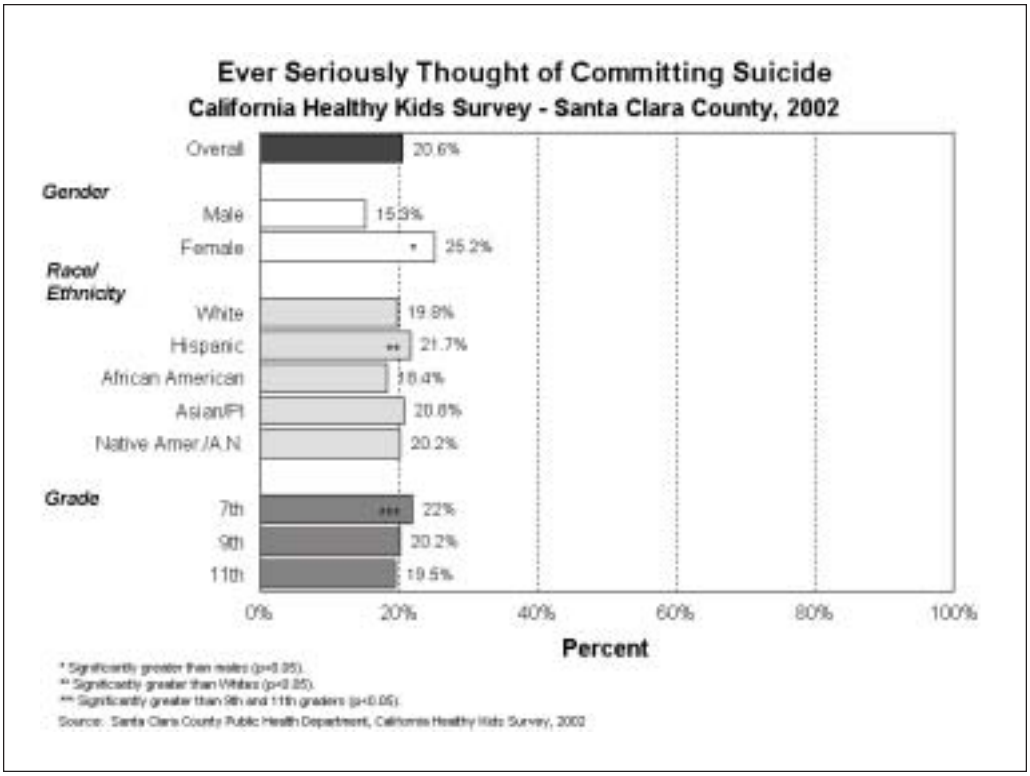
Approximately 13% of students reported that they had ever made a suicide plan. A higher proportion of female high-school students (16%) reported that they had ever made a suicide plan than males (10%). Native American (24%) students reported the highest prevalence of ever making a suicide plan compared to other race/ethnicity groups (Figure 111).

Overall, 7% of middle school students surveyed reported that they had attempted suicide in the past (Figure 112). More female middle school students reported that they had attempted suicide than males. Among Hispanic students, females (14%) were significantly more likely than males (8%) to report attempted suicide. Hispanic (11%) and African American (8%) middle school students were more likely than Whites and Asian/PIs to report attempted suicide (Figure 112).

Almost 9% of high-school students surveyed reported that they had attempted suicide in the last 12 months (Figure 113). Female high-school students (11%) reported significantly more often than males (6%) that they had attempted suicide in the past 12 months.

Among students who had reported that they had attempted suicide, one-quarter reported that they suffered an injury as a result of a suicide attempt in the past 12 months (Figure 114).

Figure 110



Suicide continued

Figure 111

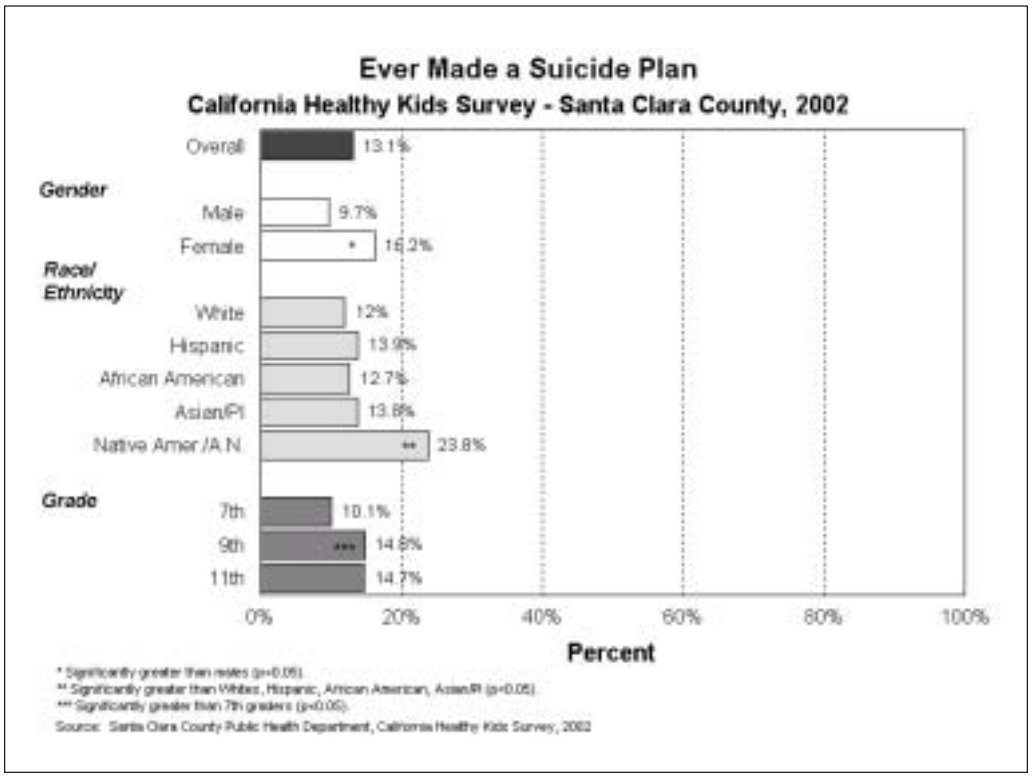
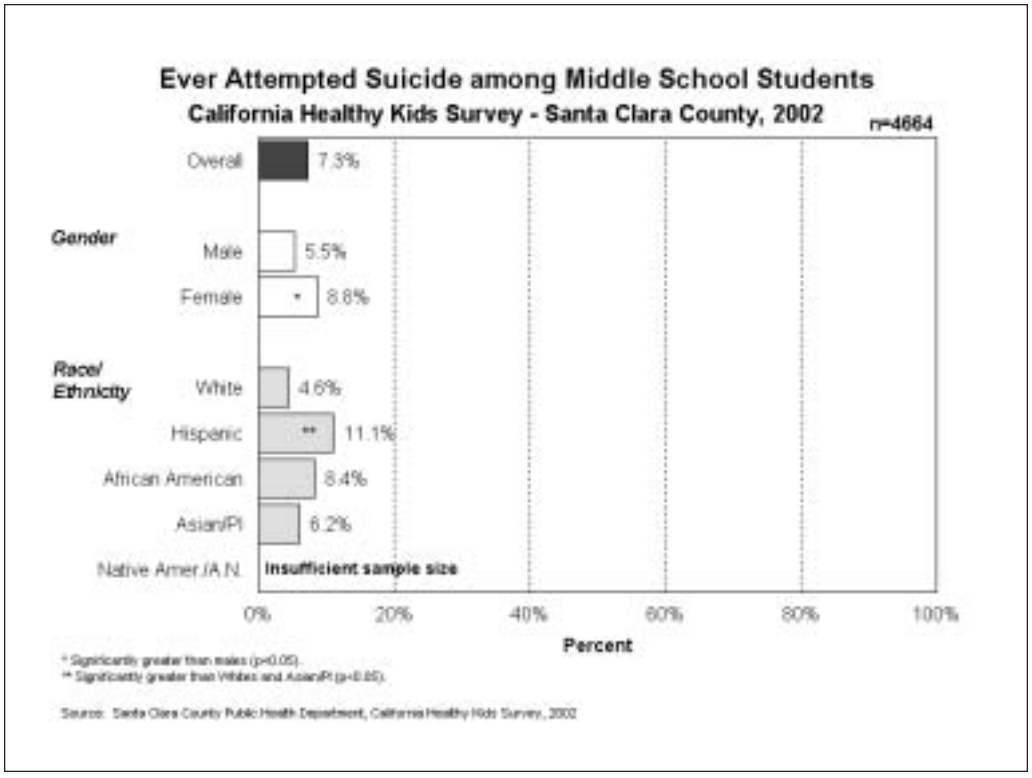


Figure 112



Suicide continued

Figure 113

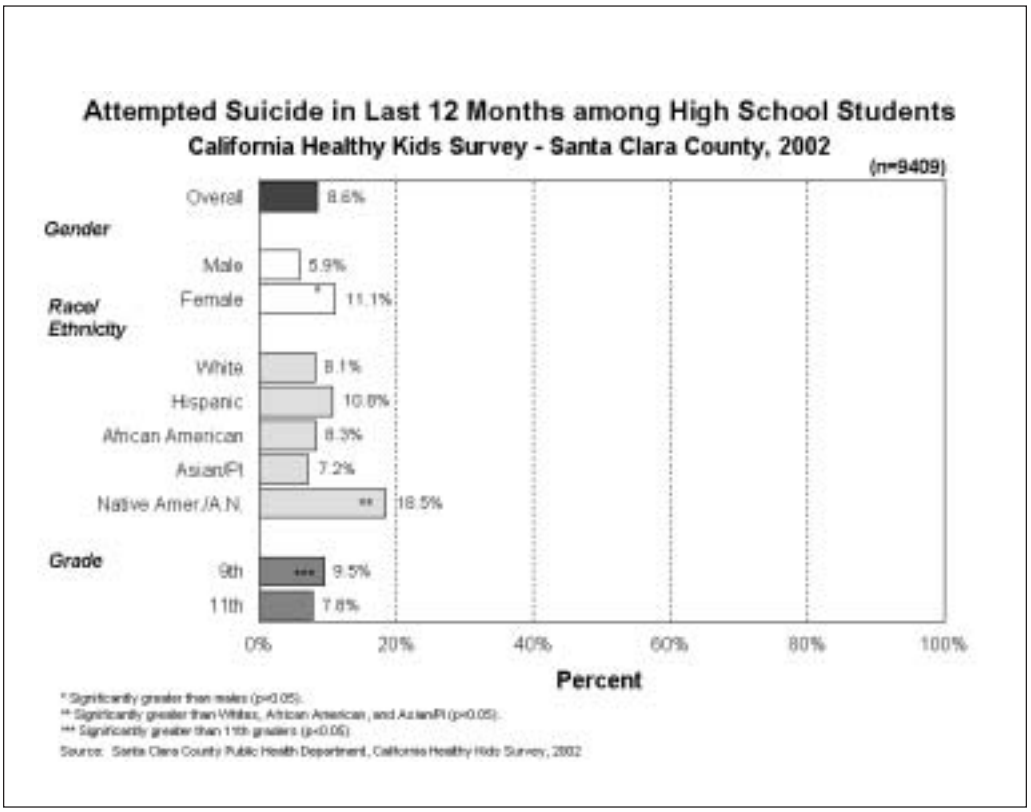
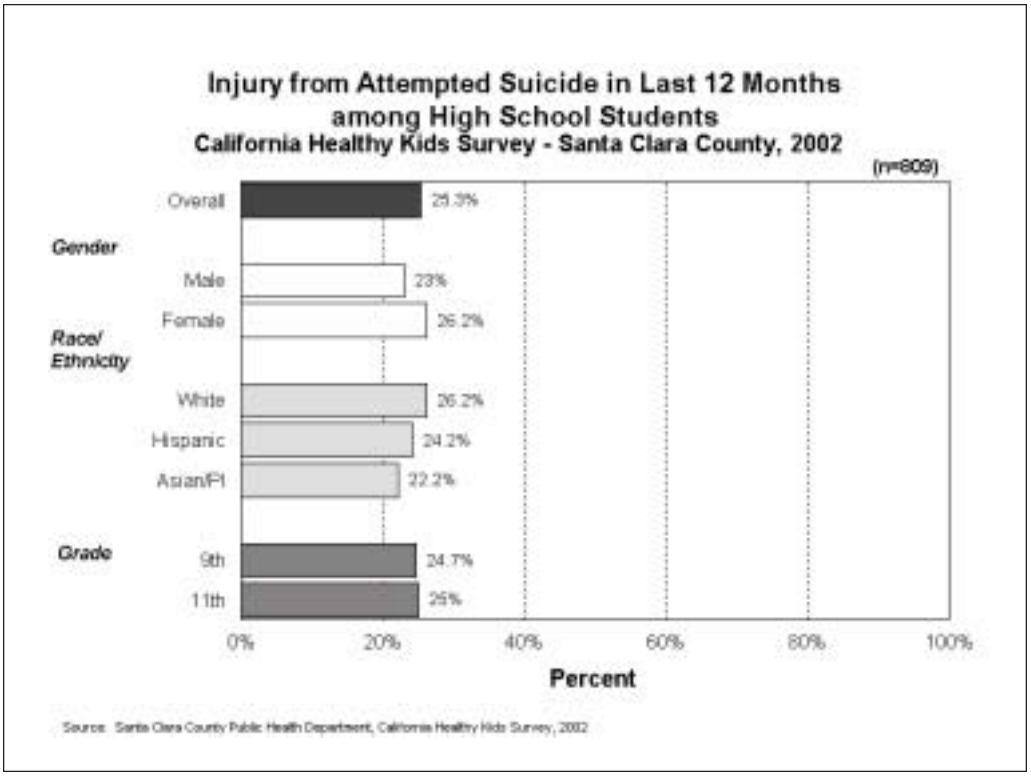


Figure 114



Family Stability

Family Composition

Family composition and access to resources and support influence the stability of families. Parents and other caregivers play a primary role in the physical, social, emotional, and cognitive development of children. Additionally, the ability of caregivers to fulfill this role may rely, in part, on access to resources and services offered by local agencies, such as welfare, child support, and foster care. Indicators in this section include one- and two-parent households, families receiving welfare, child support, foster care and adoption, the educational status of parents, domestic violence, and child abuse.

One and Two-Parent Households

Children living at home with both parents grow up with more financial and educational advantages than youngsters raised by one parent, as U.S. Census Bureau statistics have long shown. More than one-quarter of America's children now live with one parent. Parents who have never been married are significantly younger than divorced parents and, on average, tend to have completed fewer years of school and have lower levels of income.[73]

Table 31
Percent of Household Types with Children Under 18 Years

	Married-Couple Households	Female Householder (no husband present)	Male Householder (no wife present)
Santa Clara County 2000	28	5	2
California 2000	26	7	3

*Source: U.S. Census Bureau, 2000

Of the 565,863 total households living in Santa Clara County, 28% (157,192) were two-parent (married couples) households with children under 18 years,15% (28,653) of households consisted of female householders (no husband present) with children under 18 years, and 2% (11,400) consisted of male householders (no wife present) with children younger than 18 years during the 2000 Census. These figures were similar to household types with children for the state, with California having slightly lower percentages of single-family householders (either female or male householder with no spouse present) than in the county.[74]

Child Support

The mission of the Santa Clara County Department of Child Support Services (formerly the Family Support Division) is to promote the well-being of children and the self-sufficiency of families by delivering services that meet the financial, medical, and emotional needs of children. The Department is dedicated to providing a program that puts the security of children first, based on the belief that parental responsibility includes financial, medical, and emotional support.

Child support is money paid by both parents to meet their child's living and medical expenses. In addition to child support, the court may also order payment of expenses such as childcare, doctor and dental bills, and transportation. Persons who receive CalWORKS, Foster Care, or Medi-Cal benefits must trade their right to child support to Santa Clara County in exchange for these benefits.

To help ensure parental obligations of child support, the Department of Child Support Services offers assistance in establishing paternity, locating parents, requesting child and medical support orders from the court, enforcing child and spousal support orders, modifying child support orders, and processing child support payments.[75]

During the fiscal year ending June 30, 2001, the Department of Child Support Services collected almost $96.1 million of child support payments, up 7.8% from the previous fiscal year ($89.1 million). Of the total payments collected in FY2001, $75.9 million were distributed to families, while the remaining $20 million were reimbursed to welfare agencies, such as CalWORKS, Foster Care, and Medi-Cal. Similarly, $68.7 million were given to families in FY2000, while the remaining $20 million were reimbursed to welfare. More funds were given to families in FY2000 due to prior changes in federal distribution rules. The Santa Clara County Department of Child Support Services managed 73,065 cases in FY2001.[76]

During fiscal years 2001 and 2002, more than half of the child support payments were collected through wage assignments, which are court-ordered deductions from the non-custodial parents' wages for child support. Approximately 25% of the collected payments were direct payments from non-custodial parents owing support. Although the amount of child support payments not made by non-custodial parents (arrearages) figures are not available for Santa Clara County, a study by the Franchise Tax Board in May 1999 estimated that $12.9 billion due in payments was not made by non-custodial parents in California with only $4.1 billion attributed to individuals who filed a state or federal tax return. Similar to the state, the majority of non-custodial parents paying child support in the County had an average income of $18,143 a year.[77]

Families Receiving Welfare/Public Assistance

Government assistance programs in Santa Clara County provide support for the economic and social well-being of families and children, and have a positive impact on the quality of life and development of children. Although public assistance can vary from cash and food assistance to support for work preparation, programs that generally affect the lives of local children are Medi-Cal, Food Stamps, CalWORKS, Foster Care Cash Aid, Refugee Cash Assistance Program, Cash Assistance Program for Immigrants (CAPI), and the County's General Assistance Program. These programs are administered by the Santa Clara County Social Services Agency, which receives federal funding from the Administration for Children and Families under the U.S. Department of Health and Human Services.

Between 2001 and 2002, Medi-Cal assistance increased by 24% (13,971 cases), Food Stamp assistance increased by 22% (797 cases), the County's General Assistance Program increased by 20% (219 cases), and the Foster Care Cash Aid increased slightly by 4% (84 cases). Programs that declined in caseloads were the Refugee Cash Assistance Program (39%, or 35 fewer cases), and Cash Assistance Program for Immigrants-CAPI (14%, or 124 fewer cases).

In July, 2002, a total of 100,589 residents in Santa Clara County were receiving Medi-Cal assistance, 9,542 were receiving Food Stamps, 2,147 were receiving Foster Care Cash, 1,375 were receiving General Assistance, 783 were receiving CAPI, 63 were receiving Refugee Cash Assistance, and 10,400 were part of CalWORKS caseloads.[78]

Participation in California Work Opportunity and Responsibility to Kids (CalWORKs), a state welfare program that provides immediate short-term assistance (i.e. cash aid, housing, food, utilities, clothing, or medical care) to eligible needy families with children, increased by 8% in 2001-02. In 2002, CalWORKS enrollees represented 0.7% of the population in Santa Clara County and 1.4% of the population in California. Children under the age of 18 represent nearly three-fourths of all CalWORKs recipients in the County. As of July 2002, there were 19,673 children recipients. Non-white children were disproportionately represented in the CalWORKs program. Furthermore, during the 2001-02 school year, CalWORKs recipients within Santa Clara County public schools totaled 11,684 (4.7%), whereas the state's public schools totaled 682,879 (11.0%).[78]

Foster Care & Adoption

BACKGROUND

A foster family home is a private residence that has been licensed to serve as a temporary setting for children who are dependents of the courts. This home provides a supportive and stable environment for children who cannot live with their biological parents while family problems are being resolved. One of the county's Social Services Agency's goals is to place a child in a family and home environment rather than the Children's Shelter or a group home. In most cases, the foster parents work with the Social Services Agency to assist with the reunification of the child with his or her family.[79]

Adoption is a legal process that permanently gives parental rights to adoptive parents. It means taking a child into your home as a permanent family member.[79]

Although foster care caseloads remain demanding and complex in nature, the California Department of Social Services noted that the state's caseloads have declined by 12% since 1999, which reverses the trend of increasing caseloads in previous years. This decline has been due to the decreased number of children entering foster care and the increased number of children leaving the foster care system to live with relative caregivers. Furthermore, California's Adoptions Initiative has catalyzed the 35% increase in the number of foster children being placed in permanent adoptions during 1999 to 2002.[80]

HOW ARE WE DOING?

Table 32
Foster Care Prevalence Rates per 1,000 Children

	1999	2000	2001	2002
Santa Clara County	5.4	5.9	5.5	5.4
California	10.4	10.1	9.3	9.1
Healthy People 2010 Objective	NA	NA	NA	NA

Source: California Department of Social Services, Child Welfare Services, 2002

Foster Care & Adoption continued

More than 2,500 children in Santa Clara County need out-of-home care after experiencing neglect, abuse, or exploitation. These children come from families of diverse backgrounds in the county. It is the duty of the Social Services Agency Department of Family and Children's Services (DFCS) to find these children caring, adoptive homes that match the needs of each child. The greatest need for homes exists for two or more related children (sibling groups), boys ages seven to nine, infant and preschoolers with special needs, and teenagers.[81]

Prevalence rates (per 1,000 children) of foster care placements in Santa Clara County were similar between 1999 and 2002, and were much lower than the state's prevalence rates, as seen in Table 32.[82]

In 2001, there were 2,433 youth in the child welfare supervised foster care population 0-17 years of age in Santa Clara County. Of these, 1,450 (60%) were first time entries and 473 (19%) were reentries. During the same year, 2,021 (83%) youth exited the foster care system either through reunification, adoption, guardianship, or total permanency by becoming of legal adult age.[82]

In general, more Hispanic youth were in the child welfare supervised foster care population than other ethnicities in 2001: 53% were first time entries and 53% were reentries. Similarly, Hispanic youth also had the largest percent of exits from the system (51%).[82]

The same trend was seen for the state in 2001. However, the Center for Social Services Research at the University of California, Berkeley noted that although African American children made up 7% of California's population in October 2002, they accounted for 33% of those in child welfare supervised foster care in the state.[83]

Educational Status of Parents

According to a study by the Rand Corporation in 1994, the single most important factor influencing student achievement was parents' education: Students with one or two college-educated parents performed significantly better than students whose parents were not high school graduates.[84]

According to the County's Public Health Department Behavioral Risk Factor Survey 2000 results, over one-quarter (25.6%) of adults in Santa Clara County were college graduates, followed by 24.5% having graduated from high school or passed the General Education Development (GED) test. Post-graduate work had been done by 18.8% of adults, 17.6% had some college education, and 13.3% had less than a high school degree.[40] The percentages varied between the two genders and across ethnic groups. Approximately 16% of female parents (with children under 18) and 11% of male parents had less than a high school graduation. In addition, more Hispanic parents (35%) had less than a high school degree or acquired only a high school degree/GED certification (37%) than other ethnic groups. Higher percentages of White (34%) and Asian (33%), parents were college graduates. Similarly, more Asian parents (30%) had a post graduate education, followed by White parents (23%) compared to other ethnic groups in the County.

Violence & Abuse

Violence is the threatened or actual use of physical or psychological force or power against another person, against oneself, or against groups or communities that either results in, or has the high likelihood of resulting in, injury (physical or psychological), death or deprivation.[85] Indicators in this section include domestic violence and child abuse.

Domestic Violence

Domestic violence is a pattern of abuse in an intimate relationship where one partner controls the other through force, intimidation, or the threat of violence. These abusive relationships are based on the belief that one person has the right to control another.[86]

Table 33
Rate of Domestic Violence-related
Calls for Assistance per 1000 residents

Santa Clara County 2001	3.75
California 2001	5.70

Source: California Department of Justice, 2001

Results from the adult Behavioral Risk Factor Survey 2000, published by the Santa Clara County Public Health Department, revealed that domestic violence has been prevalent in the county. Approximately 9% of adult respondents reported being injured as a child and 10% witnessed parental violence as a child. Of those who reported having been abused before their 18th birthday, 62% were abused by someone five or more years their senior.[40]

According to California Department of Justice, there were a total of 6,400 domestic violence related calls for assistance in Santa Clara County during the year 2001, with a rate of 3.75 calls per 1,000 residents and slightly lower than the state. Of these calls, 76% (4859) involved a weapon. Of the domestic violence calls that reported the use of a weapon, 87% involved a personal weapon (hands, feet, etc.), 10% involved a dangerous weapon other than a cutting instrument of firearm, 2% involved a knife or cutting instrument, and less than 1% involved a firearm.[87]

Between 1993 and 1999, 95 people died in Santa Clara County as a result of domestic violence, with age of victims ranging from 9 months to 85 years old. Furthermore, of the 18 domestic violence-related deaths in 2000, more than half involved guns.[88]

In 1999, 588 cases were prosecuted in which children either witnessed and/or experienced domestic violence. Of these cases, four children witnessed a domestic violence murder, 17 children were left without one or both parents, and one child was abandoned. During 2000, 1,866 Emergency Protective Restraining Orders were issued in the county, with about half involving children at home.[88]

Domestic violence is a significant cause for homelessness among women. In 1997, Santa Clara County emergency shelters reported that 50% of women attempting to get shelter during a one-week period cited domestic violence as their reason for homelessness.[88]

Child Abuse

BACKGROUND

Child abuse falls into several categories: physical (shaking, hitting, beating, burning, or biting a child); emotional (constantly blaming or putting down a child; excessive yelling, or shaming); or sexual (incest, any forced sexual activity, or exposure to sexual stimulation not appropriate for the child's age). Neglect can also constitute child abuse and is defined as a pattern of failure to provide for the child's physical needs (food, clothing, shelter, and medical care); or a pattern of failure to provide for the child's emotional needs, such as affection, attention, and supervision.[89] Abused children and those who witness domestic violence experience higher rates of suicide, depression, substance abuse, problems in school, and other behavioral problems later in life.

HOW ARE WE DOING?

Table 34
Incidence of Child Abuse Per 1,000 Children
(Based on Child Population 0-17 Years)

	Reported	Substantiated
Santa Clara County 2001	40.2	7.2
California 2001	56.1	12.3

Source: California Children's Services Archive, Child Welfare Services, 2001

KEY FINDINGS

According to the Santa Clara County Social Services Agency, the number of child abuse reports increased between 1998 to 2001. The number of reports were 19,228 during 1998, 20,352 during 1999, 22,206 during 2000, and 22,735 in 2001. The incidence of child abuse, based on the child population, has been consistently much lower than trends seen in the state of California.[90, 91]

Reports of child abuse are investigated and determined to be either unfounded, inconclusive, or substantiated cases. In Santa Clara County, 17.9% of child abuse referrals were substantiated in 2001.

In 2001, general neglect, physical abuse, and emotional abuse were most often reported. Most of the child abuse/neglect cases were among children between 5-14 years of age. Of all the ethnicities, Hispanics comprised the largest percent of the child abuse/neglect cases.[90, 91]

During 1999, 9% (1,812) of the children who were abused were admitted to the Children's Shelter system for Dependency Action and 963 petitions were filed in Juvenile Court. Furthermore, 5% (1,017) of abused children during the same year were given services through the Voluntary Family Maintenance and Informal Supervision programs in order to reduce abuse risk.[90, 91]

School Success

Profile of All School Types

Santa Clara County has a wide array of school types to meet the needs of all students, from preschoolers to seniors in high school. Public and private systems, home schooling, charter schools, and alternative schools all contribute to the education and successful transition of youth into adulthood. Furthermore, the Head Start Program and other early childhood programs supplement the nurturing of younger children and prepare them for elementary school. Indicators for types of schools and educational programs available to and utilized by Santa Clara County children include the percentage of children in various school types, the Head Start program, child care, and alternative schools.

Preschool: Head Start Program

The Head Start program aims to help children and families make a successful transition to elementary school by integrating education, health, and parent involvement into early childhood education. The local Head Start program offers health care, dental care, vision care, mental health services, social services, and English as Second Language (ESL) classes for children in low-income families in Santa Clara and San Benito Counties. Approximately 10% of children participating have special needs and these families do not have to comply under the low-income criteria.[92]

In comparison to state-subsidized child care, the local Head Start program focuses more on engaging parent involvement. Head Start staff meet with parents twice a month to work with parents on child rearing and socialization practices for children.

As of the spring of 2003, Santa Clara and San Benito Counties Head Start program serves approximately 2,150 preschool students at 82 sites, mostly in the Santa Clara County region. Forty-six of these classroom sites are dedicated to full-day services from 7 a.m. to 6 p.m. for children of parents who work full time. Another 23 sites are half-day morning and afternoon services for children whose parents either work half time or do not work. An additional 13 Head Start sites are in collaboration with Parkway Child Care services, and are state subsidized.

Child Care

BACKGROUND

Quality child care provides young children a safe, nurturing environment and prepares children for school by offering stimulating activities and socialization opportunities. Licensing, adequate compensation for child care workers, and worker education and training all contribute to quality child care.

KEY FINDINGS

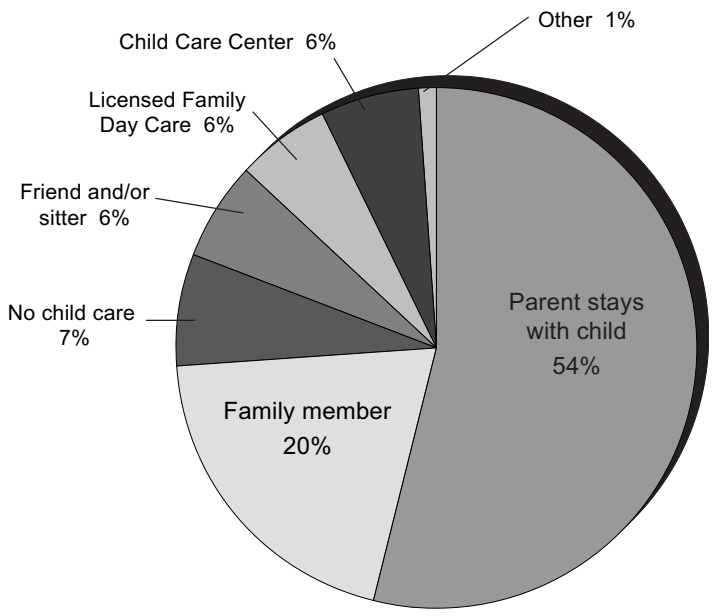
The available supply of licensed child care meets only 25% of the estimated need for licensed child care for children of all ages in Santa Clara County. There are 3.9 times more children age 0 to13 with working parents than there are licensed child care slots.[93]

In 2000, Santa Clara County was the second-most expensive county in California for preschool care (after Marin County), and was the fourth-most expensive for school-age care. Infant-care cost in the County was the highest in the Bay Area, averaging $925 a month as compared to the state average of $557 per month.[94]

Figure 115 presents the many types of child care arrangements used among parents with children ages 0-5. Over half of all children under age five are cared for by their parents.

Figure 115

Child Care Type Used for Children Age 0 - 5
Santa Clara County, 2001



Source: Community Assessment – Health and Quality of Life in Santa Clara County, 2001

Distribution of School Types

School types offered to students in Santa Clara County include public and private learning institutions from preschool to high-school level. Parents are also given the option to home-school their children or enroll them in charter schools. Charter schools are nonsectarian public schools that operate with freedom from many of the regulations that apply to traditional public schools but are still accountable to the Santa Clara County Office of Education or their local school district for academic results and fiscal practices and encourage innovative teaching practices for learning.[95]

The Santa Clara County Office of Education also directs other school types, including services for those with disabilities (Special Education), youth who are under court supervision, community schools, and preschool children of low- to moderate-income families (Head Start).

The Alternative Schools Department serves institutionalized youth at Juvenile Hall, the Children's Shelter, and the Probation Ranch facilities. The Department, as well as local school districts, also manages Community Schools, which serve youth with histories of truancy and school failure.[96]

For more information about the Head Start program or Special Education, please refer to the sections, "Special Education," or "Preschool: Head Start Program," in this domain.

In 2002, there were 347 public schools, 203 private schools, 7 charter schools, and 40 other types of schools for youth in Special Education and Alternative Schools in Santa Clara County. Furthermore, there were 647 families in the County that home schooled their children.[96] Excluding the number of pupils in Charter Schools (due to lack of data), approximately 85% of Santa Clara County students attended public schools, 14% attended private schools, less than 1% were in alternative schools, and less than 1% were home schooled during the 2001-2002 school year.[96]

During the 2001-2002 school year, 1,273 students were enrolled in Alternative School through the County Office of Education. Of these, 59% were Hispanic/Latino, 20% were White, 8% were Asian-American, 7% were African-American, 2% were Filipino-American, 2% were multiple ethnicities, 1% was Native American, and 1% was Pacific Islander.[97]

Education Profile of Public Schools

Public schools are funded through federal, state and local taxes. By law, public schools must admit and educate all children, including students with special needs. Public schools must also follow federal, state and local laws in educating children. Such laws usually include specifics about funding, program development and curriculum.[8] Indicators that measure how well schools are meeting the needs of children include attendance, truancy rates, discipline and expulsions, developmental assets, STAR scores, Academic Performance Index (API) scores, preparedness for college, high school drop out rates, and special education participation.

Developmental Assets

Developmental assets are the building blocks or experiences, skills, and values youth need for healthy development. The Search Institute of Minneapolis, Minnesota identifies these assets as internal (personal characteristics) and external (support provided by family, friends, and school) assets. The Search Institute asserts that youth should possess 31 or more of the 40 assets identified to promote healthy development. Youth who possess more developmental assets are more likely to strive in life and less likely to get in trouble or engage in risky behaviors.[98]

In November-December 1999, the Cornerstone Project worked collaboratively with Santa Clara County public school districts and the Office of Education to survey almost 7000 students in 7th to 12th grade to determine which of the 40 designated "developmental assets" they possessed. Survey results showed that only 6% of Santa Clara County students reported possessing 31 or more assets. The average number of assets reported was 18.2, leading researchers to believe that the developmental infrastructure of the County's youth is fragile. In general, older youth had lower average asset levels than their younger counterparts. In addition, young males experienced fewer assets than females.[98, 99]

Academic Achievement

In California's public schools, academic achievement is measured by the Stanford 9 "STAR" exam. The purpose of the standardized exams is to determine how well students are learning skills and knowledge required by the California Academic Content Standards for each grade or course. The Stanford 9 "STAR" exam determines the achievement of each student compared to a national sample of students tested in the same grade at the same time of the school year.

Table 35
Stanford 9 STAR Percentile Scores

Grade	2	3	4	5	6	7	8	9	10	11
Santa Clara County										
Reading	64	58	62	58	60	59	61	47	44	45
Math	72	71	69	68	70	64	64	67	59	58
Science								56	57	52
California										
Reading	53	47	49	46	48	48	49	34	34	37
Math	62	62	58	57	60	52	50	52	46	47
Science								46	37	59

Source: California Department of Education, 2002

Compared to statewide scores at each and every grade level, Santa Clara County students fared higher in reading, math, and science.[100] The numbers in the table above indicate the percentage of students in the county scoring above the 50% national percentile rank (those students with scores that correspond to student scores in the top half of the 1995 national sample, also referred to as the percent of students scoring at or above grade level).

API Scores

The Academic Performance Index (API) is an academic measure used by the State of California to assess and compare school performance and progress. This numeric index rates school performance on a range from 200 to 1000. An API score of 800 has been set as a goal for all schools by the State. Stanford 9 "STAR" results are used for calculating each school's API.[101]

Table 36
API Scores

	Percent of Schools Meeting API Growth Target (2000-2001)
Santa Clara County (Spring 2000)	78
California	70

Source: Santa Clara County Office of Education, 2002

Santa Clara County's median base API (Spring 2000) was 740. According to the California State Department of Education, 78% of Santa Clara County schools met their school-wide growth target for the school year 2000-01, compared to 70% of California schools. In Santa Clara County, 39% of schools received API scores of 800 or better, while 19% of schools statewide received scores of 800 or better. Of the top 50 schools in the state, 36% are located in Santa Clara County.[102]

Preparedness for College

A college education builds on knowledge and skills acquired in earlier years, so a solid and broad high-school education is the best preparation for college. Therefore, it is beneficial for children to start planning a high-school course schedule by 7th or 8th grade. Research shows that students who complete algebra and geometry by the end of 9th grade are more likely to go to college than those who do not. By taking these courses early, students are prepared to take high-level math and science courses after 9th grade.[103] High-school students should also maintain good grades, as high-school transcripts are an important part of any college application.

The Scholastic Aptitude Test (SAT) measures skills determined to predict students' academic success. Many colleges and universities use the SAT as one indicator of a student's readiness to do college-level work. The two sections, verbal and math, are each scored on a scale of 200-800 for a combined total of 400-1600.[104] The ACT Assessment® is also designed to assess high-school students' general educational development and their ability to complete college-level work. The test covers four skill areas: English, mathematics, reading, and science reasoning.[105]

During the 2000-2001 school year, 8,040 (48%) of the County's 16,630 high school seniors took the *SAT* (3,717 males and 4,323 females). The ethnic breakdown for the test takers whose ethnicities were known was American Indian (<1%), Asian (38%), Latino/Hispanic (10%), African American (3%), and White (27%). The County Verbal/Math averages for the SAT were 1071, slightly higher than the State average of 1008. East Side Union High School District had the lowest Verbal/Math average in the County (962) and Palo Alto Unified had the highest (1229).[106]

Advance College Test (ACT) scores ranged from a low of 1 to a high of 36. The average score for County students (23.1) was slightly higher than the state average (21.3). Gilroy Unified had the lowest average (20.1) and Palo Alto Unified and Los Gatos-Saratoga High had the highest average (25.6).

Advanced Placement (AP) examination grades are reported on a 5-point scale of qualification for recommendation to receive college credit or advanced placement (5-extremely well qualified, 4-well qualified, 3-qualified, 2-possibly qualified, and 1-no recommendation). Rates of qualification for college credit are calculated by dividing the number of students receiving qualified scores by the total enrollment of students in Grade 12 (Meeting Criteria Rate). In 2001, the AP rate was 28.2 in Santa Clara County. The State rate was 17.5 for the same year. Morgan Hill Unified had the lowest rate of students receiving a score of 3 or more (8.1) and Palo Alto High had the highest rate (108.2). The County's AP Meeting Criteria Rate for males was 29.6 and for females was 30.5. Latino/Hispanics and African Americans had the lowest Meeting Criteria Rate (6.4) and Asians had the highest rate (36.4).[106, 107]

School Performance

BACKGROUND

Success in school prepares a student to be a productive adult. Schools prepare students for jobs, higher education and civic participation. However, negative factors learned and practiced by school-age children can also lead to poor school performance.

KEY FINDINGS

Analysis of CHKS results revealed that factors associated with poor academic performance included being a smoker, being an alcoholic, and ever using any drug. Other behaviors associated with poor academic performance include being in physical fights with peers, ever having sexual intercourse, ever thinking of committing suicide, and watching TV for more than two hours during school days. Students who had asthma were more likely to perform poorer in class compared to those who did not have asthma. Socio-demographic variables such as male gender, higher-grade level, Non-White race/ethnicity and Non-Asian/PI race/ethnicity were also strong predictors for poor academic performance.

One in every four students reported receiving mostly A grades in their classes (Figure 116). Overall, 57% reported receiving A and B grades. Approximately 16% of the students surveyed reported receiving C's or lower grades.

Significantly more boys than girls reported receiving C's or lower grades (Figure 117). Girls achieved higher grades than boys irrespective of grade level (data not shown).

The proportion of students who reported receiving C's or lower grades was lowest among Asians/PIs. It was highest among Hispanics, with nearly 28% reporting receiving C's or lower grades.

Academic performance seems to fall as students grow older: 11% of 7th graders reported receiving C's or lower grades; 20% of 11th graders reported receiving C's or lower.

Figure 118 shows the factors associated with poor academic performances after adjusting the effect of socio-demographic variables in a logistic regression model.

The adjusted odds ratios suggest that being a smoker, being an alcoholic, and ever using any drugs were independently associated with poor academic performance. Other behaviors associated with poor academic performance included being in physical fights with peers, ever having sexual intercourse, ever thinking of committing suicide, and watching TV for more than two hours during school days.

Socio-demographic variables such as male gender, higher-grade level, Non-White race/ethnicity and Non-Asian/PI race/ethnicity were strong predictors for poor academic performance.

School Performance continued

Figure 116

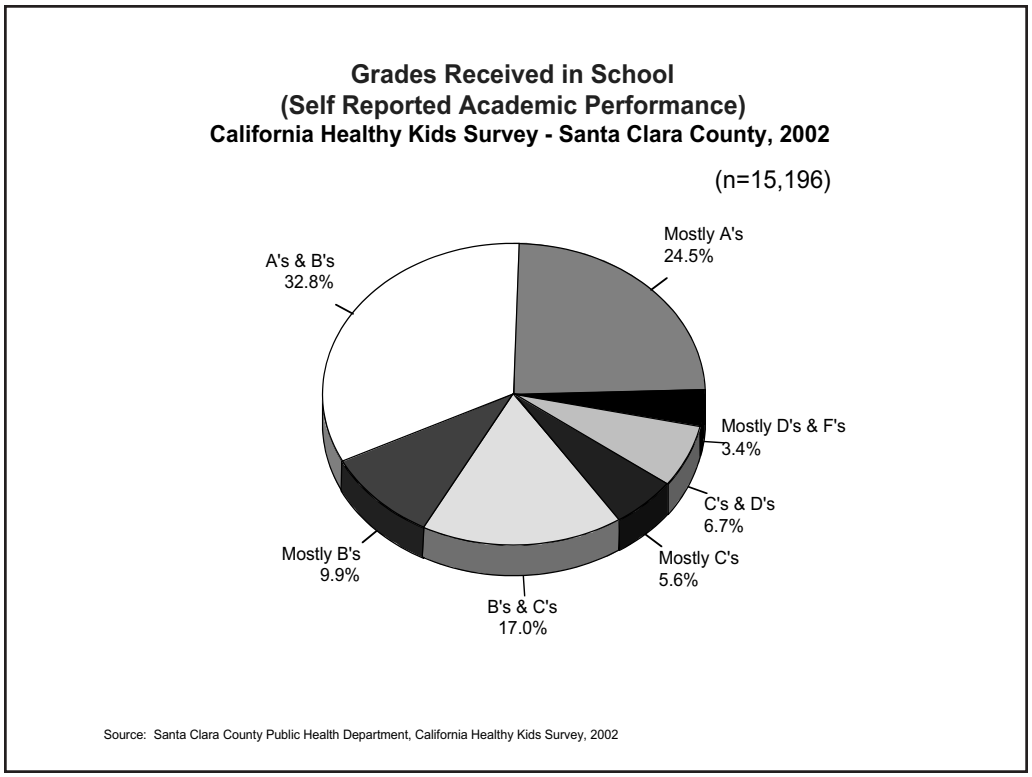
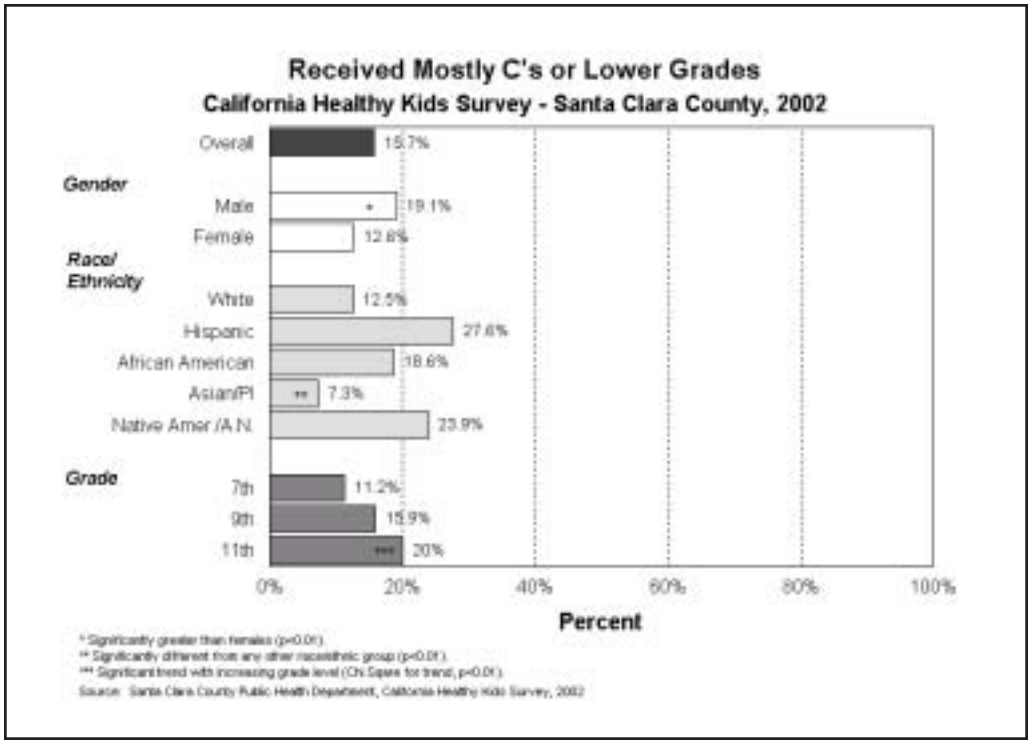


Figure 117



School Performance continued

Figure 118

Factors Associated with Poor School Performance*: Adjusted Odd Ratios
California Healthy Kids Survey - Santa Clara County, 2002

Variables	Odd Ratios (95% CI)
Currently Smoking (Yes=1, No=0)	1.71 (1.41, 2.08)
Ever had alcoholic drink (Yes=1, No=0)	1.30 (1.11, 1.50)
Ever had any illegal drug (Yes=1, No=0)	1.54(1.31, 1.80)
Involved in physical fight at school property, last 12 mo (Yes=1, No=0)	1.54 (1.33, 1.77)
Ever had sexual intercourse (Yes=1, No=0)	1.54 (1.32, 1.78)
Ever have thought of committing suicide (Yes=1, No=0)	1.54 (1.33, 1.78)
Watch TV for >=2 hour on a week day (Yes=1, No=0)	1.47 (1.30, 1.67)
Gender (Male=1, Female=0)	1.64 (1.44, 1.86)
School grade (9th and 11th=1, (7th=0)	1.66 (1.40, 1.95)
White race/ethnicity (Yes=1, No=0)	0.42 (0.22, 0.79)
Asian race/ethnicity (Yes=1, No=0)	0.25 (0.13, 0.47)
Have asthma (Yes=1, No=0)	1.18 (1.03, 1.35)

* Received most C or lower grades; ** Asked only to High School students
Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

Attendance

California compulsory education law requires every child between the ages of 6 and 18 years to attend school, except 16 and 17 year-olds who have graduated from high school or passed the California High School Proficiency Exam (CHSPE) and obtained parental permission to leave. In California, average daily attendance of students in public schools is important because it is a major determining factor in the allocation of per pupil expenditures.[108]

There were 289,108 students enrolled in grades K-12 during the 2001-2002 school year in Santa Clara County. According to the Santa Clara County Office of Education, the average daily attendance (ADA) for all County public schools in the 2000-2001 school year was 94%. Among elementary schools, Loma Prieta Joint Union School District had the highest ADA at 98%, closely followed by Cupertino Union and Los Altos School Districts, both at 97.5%. The district with the lowest ADA was Campbell Union at 88.5%. Among secondary schools, Los Gatos-Saratoga Joint Union School District had the highest ADA in the County at 96%. Gilroy Unified School District's average daily attendance was the lowest among secondary schools at 88.5%.[109]

Truancy Rates

Legal truants are considered youth who have three unexcused absences or three tardies of more than 30 minutes from school, or any combination without valid excuse. Students who have six unexcused absences or six tardies of more than 30 minutes from school, or any combination without valid excuse are considered to be habitual truants and may be referred to the district attorney's office for legal action as status offenders.[4]

Although truancy and excessive absenteeism are not new problems, they cause costly, long-term problems for students, school, and the community.[110] When students continue to miss school, they forfeit the benefits of an education, concepts that are important in understanding subjects, socialization skills, and life skills, such as the capacity to understand, follow directions, and plan for the future. Furthermore, state financial support for schools is directly linked to student's average daily attendance and schools do not receive funding for truancy. Hence, with less revenue, school districts have reduced ability to offer educational programs for all students. Studies have shown that criminal activity increases when students are not in school.[4]

Almost 18,000 youth in Santa Clara County were truant (had six or more whole-day unexcused absences) during the 1998-1999 school year. Of the total county school enrollment of approximately 250,000 students during 1998-1999, 8% were at risk of failing school due to truancy.[111]

Discipline/Expulsion

California Education Code 48915(c) states that mandatory expulsions are for acts that are committed by students at school or during a school activity. These involve possessing, selling or otherwise furnishing a firearm; brandishing a knife at another person; selling a controlled substance; committing or attempting to commit a sexual assault; and possessing an explosive.[112]

Table 37
Total Number of Mandatory Expulsions

	2000-2001	2001-2002
Santa Clara County	41	65
California	1,839	1,586

Source: California Department of Education, 2002

There were 41 mandatory expulsions during the 2000-2001 school year in Santa Clara County; about 2% of all expulsions in California. In the 2001-2002 school, there was a slight increase in the number of mandatory expulsions with 65 in Santa Clara County, or 4% of all expulsions in the state.[113]

High School Dropout Rate

The California Department of Education defines a high school dropout as a person who was formerly enrolled in grades 7, 8, 9, 10, 11, or 12; has left school for 45 consecutive school days and has not enrolled in another public or private educational institution or school program; has not re-enrolled in the school; has not received a high school diploma or its equivalent; and was formerly enrolled in a school or program leading to a high school diploma or its equivalent. This includes students who have moved out of the district, out of state, or out of the United States and are not known to be in an educational program leading toward a high school diploma or its equivalent.[114] On average, youth who drop out of high school earn less income over time and are less likely to find and keep a job than youth who complete high school.[115]

Over the past three years, high-school dropout rates per 100 students in Santa Clara County decreased slightly, from 2.2% in 1998 to 1.6% in 2001. The state's high school dropout rate in 2001 was 2.8%. The four-year derived dropout rate for high-school students was 6.3% for Santa Clara County and 11% for California.[116]

During the 2000-2001 school year, 12th graders had the highest dropout rate (3.8%), followed by 11th graders (2.8%), and 9th and 10th graders (2.4% each). Among junior-high students, 0.9% of 8th graders and 0.7% of 7th graders dropped out of school in 2000-2001.[116]

Among 9th to 12th graders in Santa Clara County in 2000-2001, the highest dropout rates were seen among Hispanics/Latinos (12.5%), followed by American Indian/Native Alaskans (10.5%), and African Americans (9.1%).[116]

Special Education

BACKGROUND

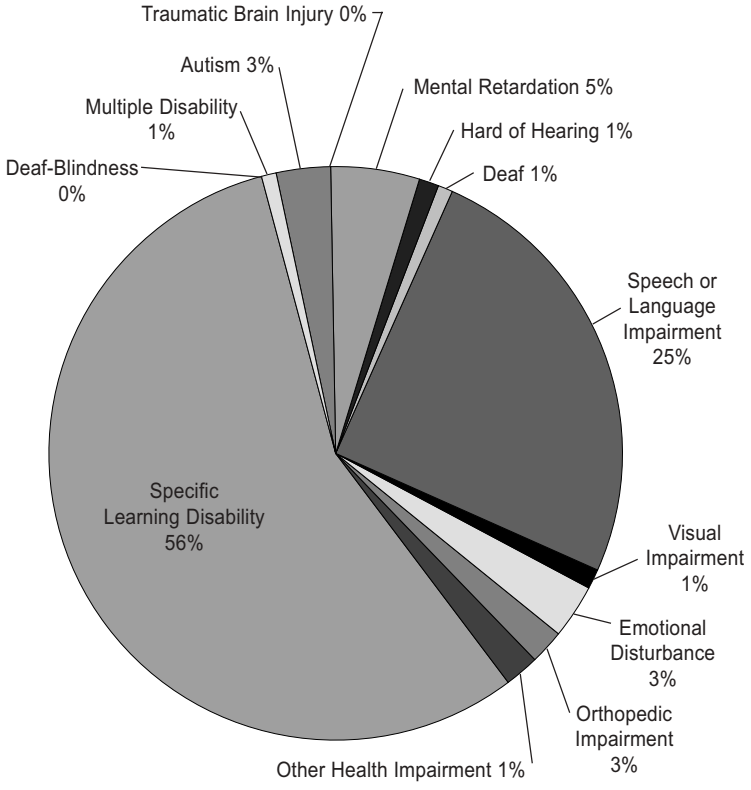
With the passing of the federal law (Public Law 94-142) in 1975, mandates were established for assuring free and appropriate public education for all students with disabilities. "The Education for All Handicapped Children Act" of 1975 mandated that students with disabilities be provided an appropriate education designed to meet their unique needs in the least restrictive environment. The act also required that students with disabilities be educated to the maximum extent appropriate with peers without disabilities. Major amendments to the law have added infants and toddlers (P.L.99-457), changed the title of the law to Individuals with Disabilities Education Act (IDEA), and added other refinements to the provisions. Under the law, for each child with a disability, an Individualized Education Program (IEP) must be developed in collaboration with the parents of the child.

Under IDEA, the disability categories include Specific Learning Disability, Speech or Language Impairments, Mental Retardation, Hearing Impairment including Deafness, Visual Impairment including Blindness, Emotional Disturbance, Orthopedic Impairment, Other Health Impairments, Autism, Traumatic Brain Injury, Multiple Disabilities, and Deaf-Blindness.

KEY FINDINGS

During the 2001-2002 school year, 25,770 students up to 22 years of age were enrolled in special education programs in Santa Clara County schools. This is close to 4% of statewide special education enrollment. More than one-half of the special education students were identified as having a specific learning disability (Figure 119).

Type of Disabilities Among Special Education Enrolled Students
Santa Clara County, December 2001



Source: California Department of Education, 2001

Figure 119

Classroom & Teacher Profile

Classroom environment and teacher preparation influence the learning of students. Indicators such as classroom size and per pupil expenditures can affect student success. Teacher credentials and teacher salaries impact the quality of education, assuring that skilled teachers are recruited and retained. All teachers in a public school must be state certified or, at a minimum, working toward certification. Certification ensures that a teacher has gone through the training required by the State of California, which includes student teaching and coursework.

Teacher Credentials and Salaries

A standard measure for teacher quality is certification. A fully certified teacher holds a preliminary, clear, professional clear, or life credential, and has completed a teacher preparation program. Since statewide class reductions were put into place in 1996, the demand for teachers has skyrocketed. With more new classrooms and smaller class sizes, it is challenging for school districts to find all the teachers they need. The teacher shortage means that non-accredited teachers are more likely to be hired with emergency permits. With more job options, accredited teachers are more likely to choose the more affluent districts that have more resources, leaving the low-income school districts with non-accredited teachers who may not have the necessary skills.[115] During 2003, the teacher supply situation has been complicated by severe state budget cuts, which could result in the elimination of teacher positions and other school personnel.

Of the 13,039 public school teachers in Santa Clara County, 85% were fully credentialed, 11% had emergency permits (do not quality for credential or internship but meet minimum requirements), and 2% were given waivers due to the inability to find credentialed teachers or individuals who qualify for an emergency permit (2001-2002 school year).[117]

The average teachers' salary in Santa Clara County's public school system in the school year ending June 2001 was $54,626. The school district with the highest teachers' salary average in the 2000-2001 school year was Los Gatos-Saratoga Union High School district, with an average of $65,526.[118]

According to a study by the American Federation of Teachers, California's average salary was $52,450 in the same year, which was second highest (only to Connecticut) in the nation. Hence, the County teachers' average salaries are comparable to the states' high-ranking average.[118]

Classroom Size

In 1996-97, the Class Size Reduction Program was established in California to improve the educational program, especially in reading and mathematics, for children in grades K-3. The program implemented a student-teacher ratio of twenty-to-one in those grade levels.[119] Compared to teachers with larger classes, teachers of reduced-size classes were more likely to say that they know what each student knows and can do, provide feedback on writing assignments within one day, give more individual attention to students, and are able to meet the instructional needs of all students.

Table 38
Student-Teacher Ratio

	1999-2000	2000-2001	2001-2002
Santa Clara County	20.7	20.3	19.9
California	20.9	20.7	20.6

Source: California Department of Education, 2002

For the school year 2001-02, the average class-size for Santa Clara County (26.1) was very similar to the statewide average (26.3).[120] Despite greatly reduced K–3 class sizes, the State of California ranks 50th nationally in the number of students per teacher.[121]

Overall, the student-teacher ratios in Santa Clara County mirror the trends seen in the rest of California public schools. During the 1999-2000 school year, the student-teacher ratio was 20.7 in Santa Clara County public schools, similar to the state's ratio of 20.9. In 2000-2001, the student-teacher ratio was 20.3 in Santa Clara County (versus 20.7 in the state). In 2001-2002, the student-teacher ratio was 19.9 in Santa Clara County (versus 20.6 in the state).[120]

It is important to note that the average classroom size takes into consideration the enrollment in classes divided by the number of classes, but does not include special education courses, other instruction-related assignments, and department chairs. Hence, classroom size figures differ from the student-teacher ratio, which only takes into account the number of enrolled students and not the number of classes.

Per Pupil Expenditure

Per pupil spending statistics reflect the current expense of education and average daily attendance (ADA) in California school districts as defined by the California Department of Education.

Table 39
Average Per Pupil Expenditure
1999-2000 Fiscal Year

Santa Clara County	$6,521
California	$5,462
U.S.	$6,911

Source: U.S. Department of Education, 2002

During the Fiscal Year from 1999-2000, the average spending per pupil in Santa Clara County was $6,521, which is higher than the California average of $5,462 but lower than the nation's average of $6,911. Per pupil spending in the County was $6,113 in elementary schools, $7,202 in high schools, and $6,732 in unified schools.[122, 123, 124]

Most states fund public schools with local property taxes, while California's public schools are mostly funded by the state. California has been known to have a lower-than-average spending per student compared to other states for nearly two decades, ranking 40th in the nation during 1997 to 1998. During the same time period, California spent 15% less per pupil than the national average, which was equivalent to $1,000 less per child or $30,000 less in an average classroom in a school year.[125]

School Environment

Children spend a large part of the day and year in school. Overall schools are still the safest place for children to be, but crime does occur in public schools. Exposure to crime, or threats of crime, interferes with the learning environment. Local planners and policymakers can use recent data to direct resources to various school violence and crime prevention programs. Studies show that broad-based comprehensive approaches that combine collaborative efforts of family, school, and community and focus on positive youth development and involvement result in increased academic achievement and reduced risk behaviors.[126]

School environment indicators include crimes against persons, weapon possession, drug/alcohol offenses, and perceived safety.

Crimes Against Persons

Crimes against persons include assault with a deadly weapon, battery, homicide, robbery/extortion, and sex offenses. Findings show that most school crimes result from students themselves and not from strangers intruding on the campuses. Teachers or other staff members are rarely victims. Victims and known suspects are most often students at schools where the crime takes place.[126]

Table 40
Percent of Adolescents Involved in Physical Fighting at School

Santa Clara County 2000	
9th Grade	27.2
11th Grade	24.1
California 2000	
9th Grade	NA
11th Grade	NA
Healthy People 2010 Objective	
9th - 12th Grades	33.3

Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

Crimes Against Persons continued

KEY FINDINGS

Crimes on school campuses cost Santa Clara County school districts and the County Office of Education a total of $671,854 in the 2000-2001 school year.[126, 127]

Of the 254,004 students enrolled from Kindergarten to high school, 1,121 students committed crimes against persons on school campuses. Of these offenses, 83% were charges of battery against others.[126, 127]

The California Safe Schools Assessment provides data on crime rates against persons (number of incidents per 1,000 students) in public school districts and county office of education campuses. Santa Clara County crime rates are presented in Table 40. The highest offense rate was for battery (3.67) in 2000-2001, slightly up from 3.64 in 1999-2000.[126, 127]

Although sex offense rates by Santa Clara County youth were similar to statewide rates, all other rates for crimes against persons in the County were below California rates.

Table 41
Santa Clara County Crime Rates Against Persons in Schools per 1,000 Students

	Santa Clara County		California	
Crime Type	1999-2000	2000-2001	1999-2000	2000-2001
Battery	3.64	3.67	3.88	4.58
Assault with deadly weapon	0.33	0.22	0.35	0.37
Robbery/Extortion	0.16	0.13	0.21	0.18
Sex Offenses	0.24	0.39	0.26	0.31

Source: California Department of Education, 2002.

Crimes Against Persons continued

Overall, 22% of Santa Clara County students surveyed were involved in a physical fight at school during the last 12 months (Figure 120). About twice as many males (31%) as females (15%) were involved in fights. Fighting decreased as students progressed to higher grades.

In response to questions about whether they had been harassed at school in the past 12 months, students reported being harassed for a number of reasons (Figure 121). Overall, 14% of students reported that they were harassed at school because of their race/ethnicity. African American students were most likely to report harassment because of their race/ethnicity in the past 12 months. Native American students were more likely than Whites, Hispanics, and Asian/PIs to report that they were harassed at school because of their religion.

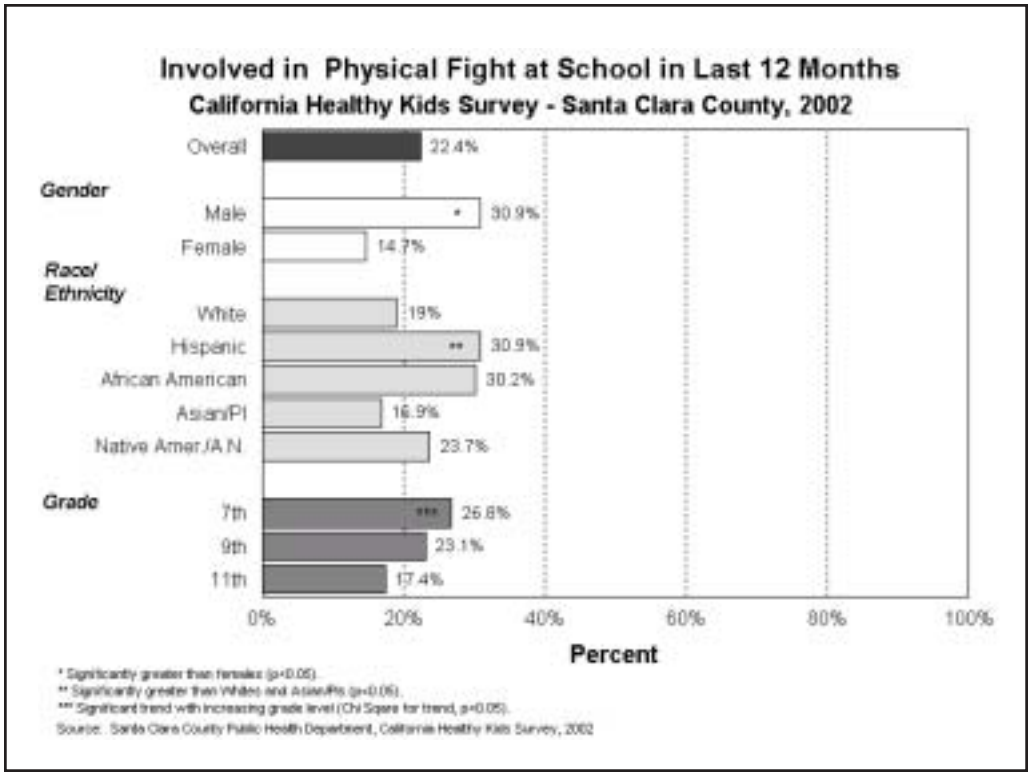
Female students reported significantly more often than males that they were harassed at school because of their gender. This pattern of female students reporting harassment more often than male students occurred in all grades and for most race/ethnicity groups. The exception was within African-American students where there was no significant difference between male (11.6%) and female (13.6%) students reporting harassment.

Overall, 7% of students reported that they were harassed at school because they are gay or lesbian. Male students reported significantly more often than females that they were harassed at school because they are gay or lesbian.

Just over 4% of students reported that they were harassed at school because of a handicap. Male students reported significantly more often than females that they were harassed at school in the past 12 months because of a handicap (Figure 121).

Overall, about 90% of students felt safe at school (Figure 122). The perception of safety among students was consistent across all grade levels.

Figure 120



Crimes Against Persons continued

Figure 121

Reasons for Harassment at School in Last 12 Months
California Healthy Kids Survey - Santa Clara County, 2002

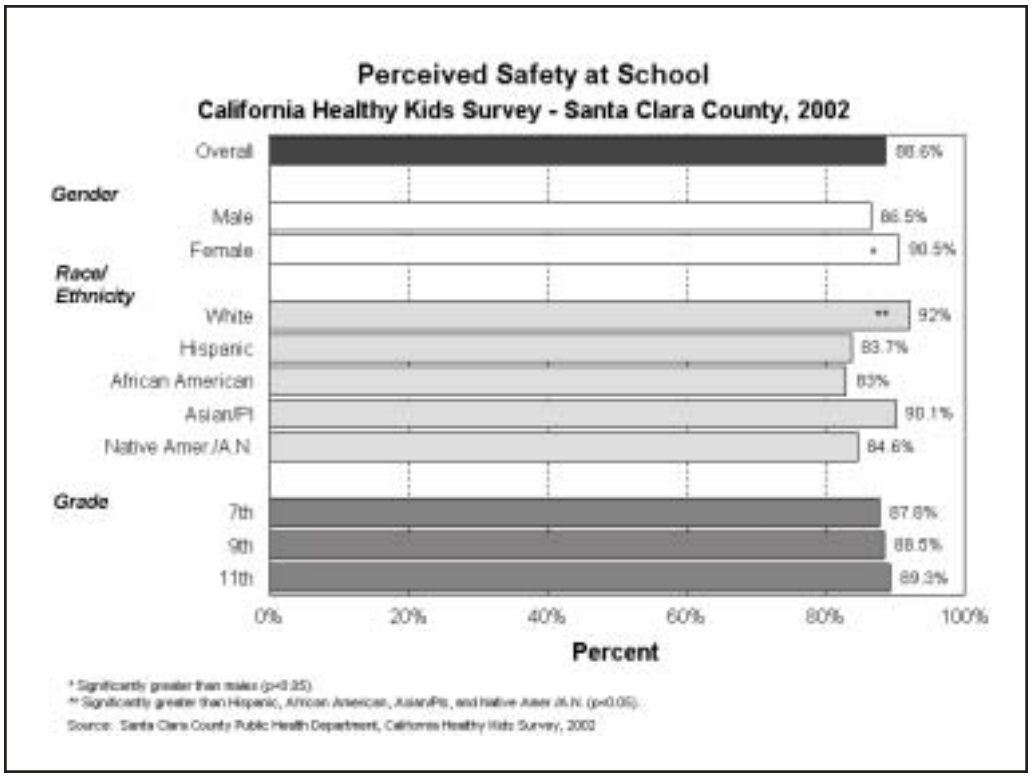
% Percent of students answering 'Yes' for the following reasons:

	Race/Ethnicity	Religion	Gender	Homosexual	Handicap	Other
Overall	14.3%	8.1%	9.6%	7.2%	4.1%	22%
Male	17.2%	9%	6.2%	8.6%	4.7%	23%
Female	11.6%	7.2%	12.8%	6%	3.6%	21.1%
White	9.9%	7.5%	10.3%	8.2%	4.1%	24.4%
Hispanic	15.7%	7.7%	10.6%	7.3%	4.4%	20.1%
African American	24.5%	10.9%	12.8%	8.9%	7.6%	23%
Asian/PI	16.9%	8.7%	7.5%	5.9%	3.4%	21%
Native Amer./A.N.	16%	16.8%	14.4%	8.7%	9.5%	21.6%
7th	13.2%	8.1%	10.2%	8.5%	4.3%	24.4%
9th	16%	8.1%	8.9%	7.1%	4.1%	23.5%
11th	13.9%	8.3%	9.9%	6.2%	4.1%	18.1%

Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

Crimes Against Persons continued

Figure 122



Possession of a Weapon

Possession of a weapon can include possession of firearms, knives, or other types of weapons.[128]

In response to the nation's "Federal Gun-Free Schools Act of 1994," which requires school districts across the country to practice "zero tolerance" policies against firearms in schools by expelling any student who brings a firearm to school for one calendar year, California amended some of its existing Education Codes (sections 48910 [c], and 48915) to fulfill the federal mandate in all school districts in the state, including Santa Clara County. In addition to the required national policy, California also requires mandatory suspension and recommended expulsion for students who (1) possess, sell or furnish a weapon; (2) brandish a knife to another person; (3) sell a controlled substance, except for the first offense of less than one ounce of marijuana; (4) commit or attempt to commit sexual assault or sexual battery; and (5) possess an explosive. Furthermore, California's policy requires that any student who commits these acts shall be referred to an alternative program of study.[128]

Table 42
Percent of Adolescents Carrying Weapon on School Property

Santa Clara County 2000	
9th Grade	5.5
11th Grade	6.9
California 2000	
9th Grade	NA
11th Grade	NA
Healthy People 2010 Objective	
9th – 12th Grades	6.0

Source: Santa Clara County Public Health Department, California Healthy Kids Survey, 2002

Possession of a Weapon continued

KEY FINDINGS

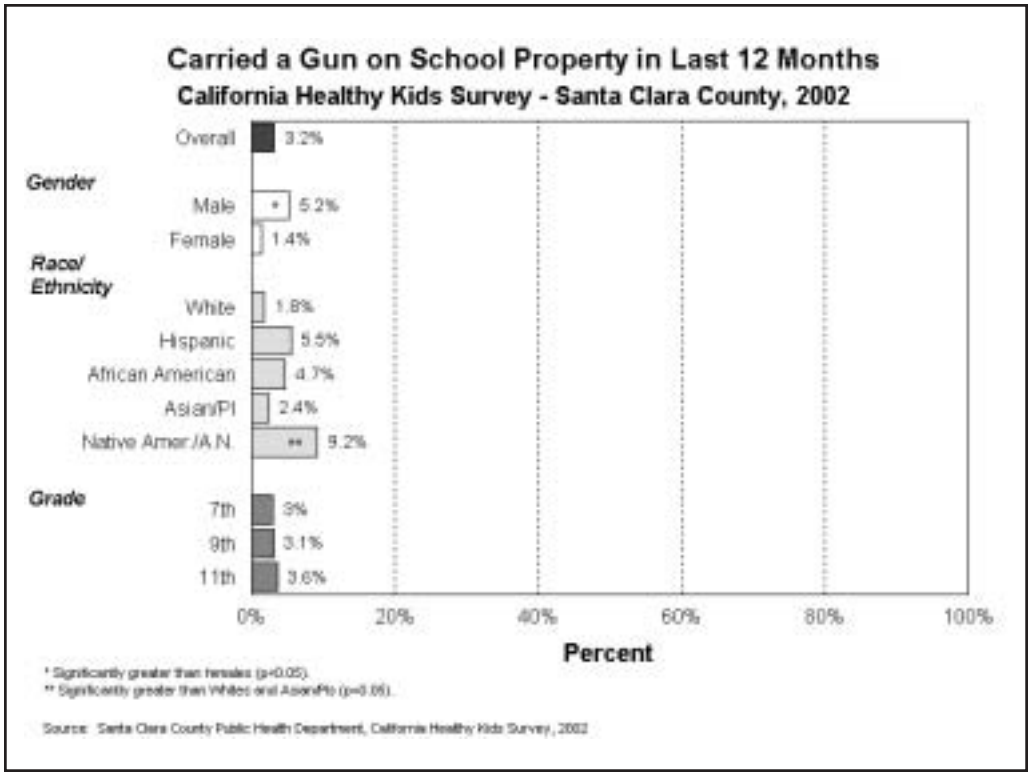
Of the 254,004 students enrolled from grades kindergarten to high school in Santa Clara County public school districts and County Office of Education program sites, 257 students committed possession of weapon offenses in the 2000-2001 school year. The rates (number of incidents per 1,000 students) for possession of weapon offenses among students in Santa Clara County public schools were 1.02 in the 1999-2000 school year and 1.01 in the 2000-2001 school year.[126]

Overall, 3% of students surveyed reported carrying a gun on school property during the past 12 months (Figure 123). Males reported significantly more often than females that they carried a gun on school property in the last 12 months. Native Americans had the highest prevalence of carrying a gun on school property.

Overall, 10% of students surveyed reported carrying a weapon other than a gun on school property during the past 12 months (Figure 124). Males were more likely to report carrying a weapon than females. Hispanic, African American, and Native American/AN students reported a higher prevalence of carrying a weapon than Asian/PI or White students. The proportion of students carrying a weapon increased as students progressed into higher grades.

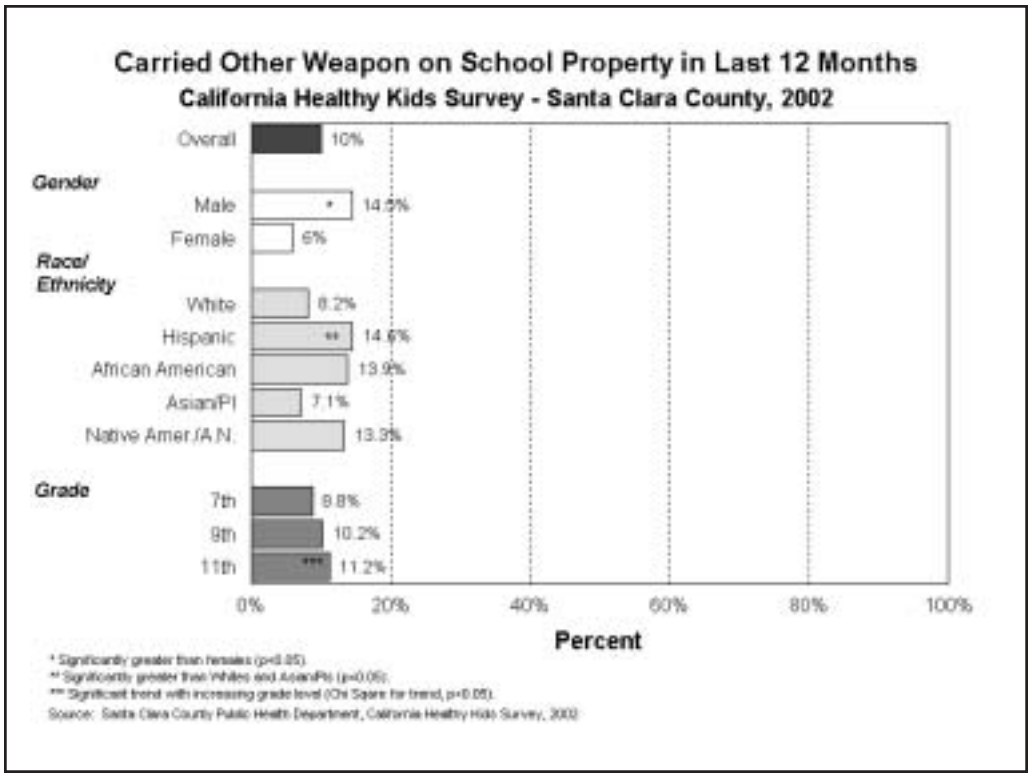
According to the Adult Behavioral Risk Factor Survey (BRFS) in 2000, 40% of adults with children under 18 years old owned a firearm. Of the 85 respondents with children under 18 years who owned a handgun, 82, or 96%, did not keep their handgun locked. In addition, of the 103 adults with children under 18 who reported owning a long gun (i.e. rifle), 97, or 94%, did not keep their long gun locked.

Figure 123



Possession of a Weapon continued

Figure 124



Drug and Alcohol Offenses

BACKGROUND

Drug and alcohol offenses generally encompass possession, use, sale, or furnishing of any drug, alcohol, or intoxicating substance, as well as drug paraphernalia that is prohibited by law, on school property. The California Zero Tolerance policy requires that any student who sells a controlled substance (except for the first offense of less than an ounce of marijuana) is liable for mandatory suspension and recommended expulsion.[128]

KEY FINDINGS

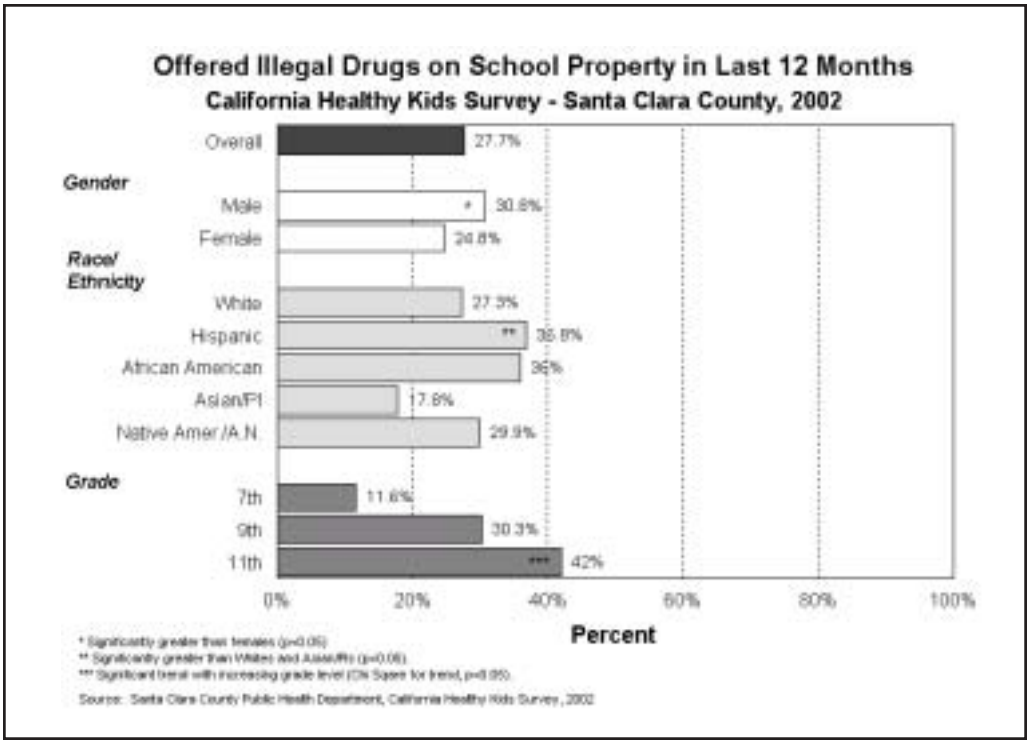
Of the 254,004 students enrolled from kindergarten to high school, 929 committed drug/alcohol offenses in the 2000-01 school year. The rate (number of incidents per 1,000 students) for drug and alcohol offenses among students during the 2000-2001 school year was 3.66, slightly higher than the previous school-year rate (3.43).[126]

Overall, 28% of Santa Clara County students surveyed reported being offered drugs on school property. High proportions of Hispanics and African Americans reported being offered drugs at school (Figure 125). Male students in all race/ethnicity groups and in all grades were more likely to report that they were offered drugs on school property than female students (data not shown).

Overall, 88% of students reported never having been drunk or "high" while on school property (Figure 126). Less than 7% of students surveyed reported being drunk or high at school three or more times. A higher proportion of Hispanic students reported being drunk or "high" while on school property than other races/ethnic groups. More 11th grade males than females reported being drunk or "high" on school property (data not shown).

Overall, 5% of students reported being in possession of marijuana on school property within the last 30 days (Figure 127).

Figure 125



Drug / Alcohol Offenses continued

Figure 126

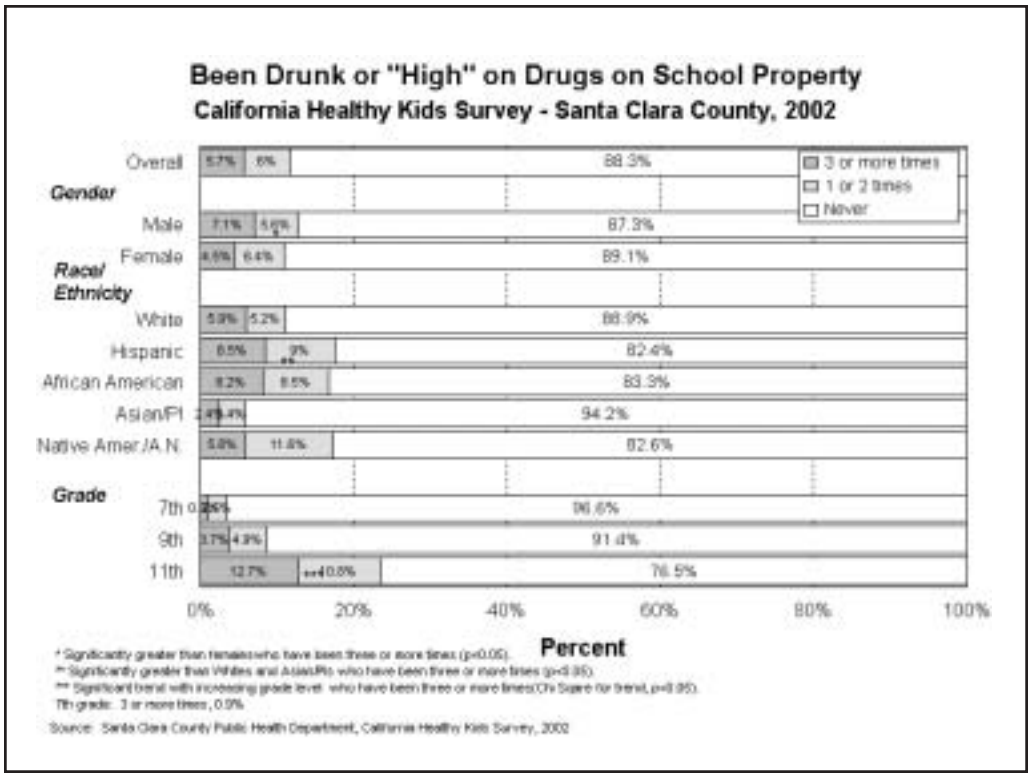
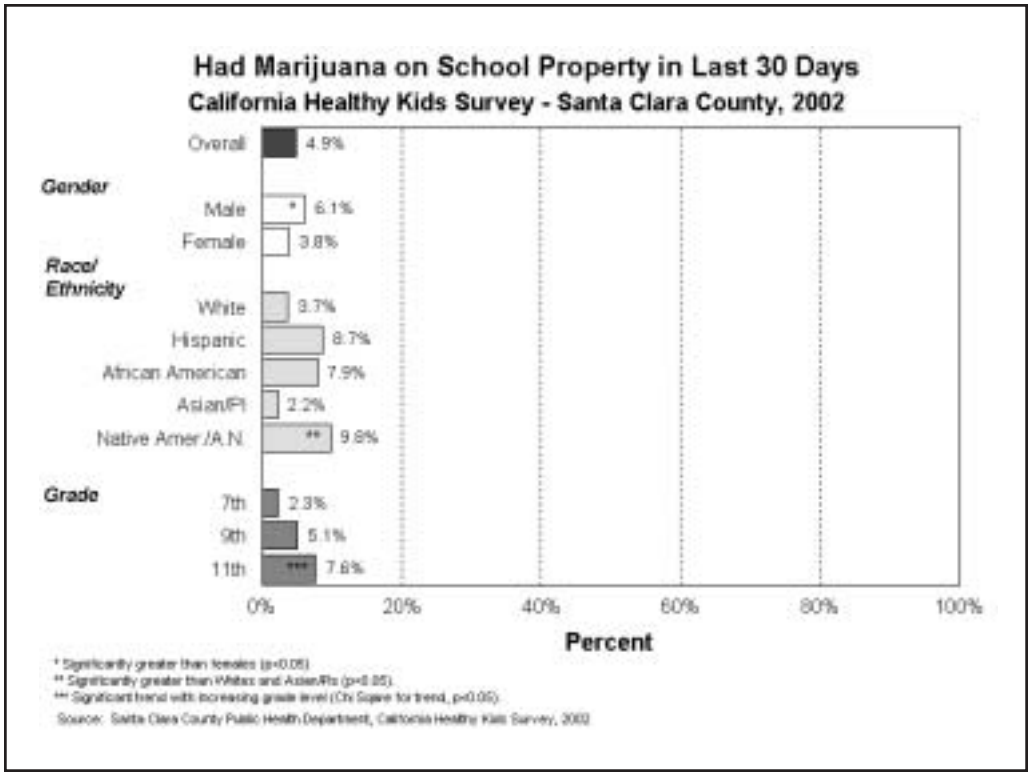


Figure 127



Community Safety

Safe Neighborhood

Living in a safe neighborhood is important for the physical safety of children and the mental perception of feeling safe while socializing outside one's home, which improves the overall quality of life for families. Indicators in this section are perceptions of safety, property crimes, hate crimes, and the presence of registered sex offenders.

Neighborhood Safety

BACKGROUND

According to the Neighborhoods USA, neighborhood safety encompasses a broad and diverse set of principles and strategies. First, streets must be safe from crime, including gang prevention and intervention. Second, homes must be safe from environmental hazards such as lead. Third, neighborhoods must be clean and adhere to environmental and housing condition standards. Fourth, a safe neighborhood is characterized by having an emergency management system in place. Fifth, a neighborhood must be a safe place to bike and walk. Sixth, a safe neighborhood is exemplified by neighbors who know one another and who maintain mutually supportive relationships. Seventh, schools within neighborhoods should be safe from violence. Finally, neighborhoods can be redesigned to prevent crime and improve safety by such strategies as the use of cul-de-sacs, lighting, speed bumps, and neighborhood portals.[129]

KEY FINDINGS

More than 90% of Santa Clara County students surveyed reported feeling safe in their neighborhoods (Figure 128). Hispanic students were least likely to perceive that their neighborhood was safe.

Of all the students surveyed, 27% reported being in at least one physical fight over the past 12 months (Figure 129). Males reported that they were involved in a fight significantly more often than females. African American, Native American, and Hispanic students were more likely than White and Asian/PI students to report involvement in a physical fight in the last 12 months. Approximately 4% of students reported that they were injured in a physical fight in the last 12 months (Figure 130). Overall, 9% of students reported having belonged to a gang, with significantly more males reporting gang involvement than females (Figure 131). Nearly 9% of students in Santa Clara County reported that they had been hit by a boyfriend or girlfriend in the past 12 months (Figure 132).

Neighborhood Safety continued

Figure 128

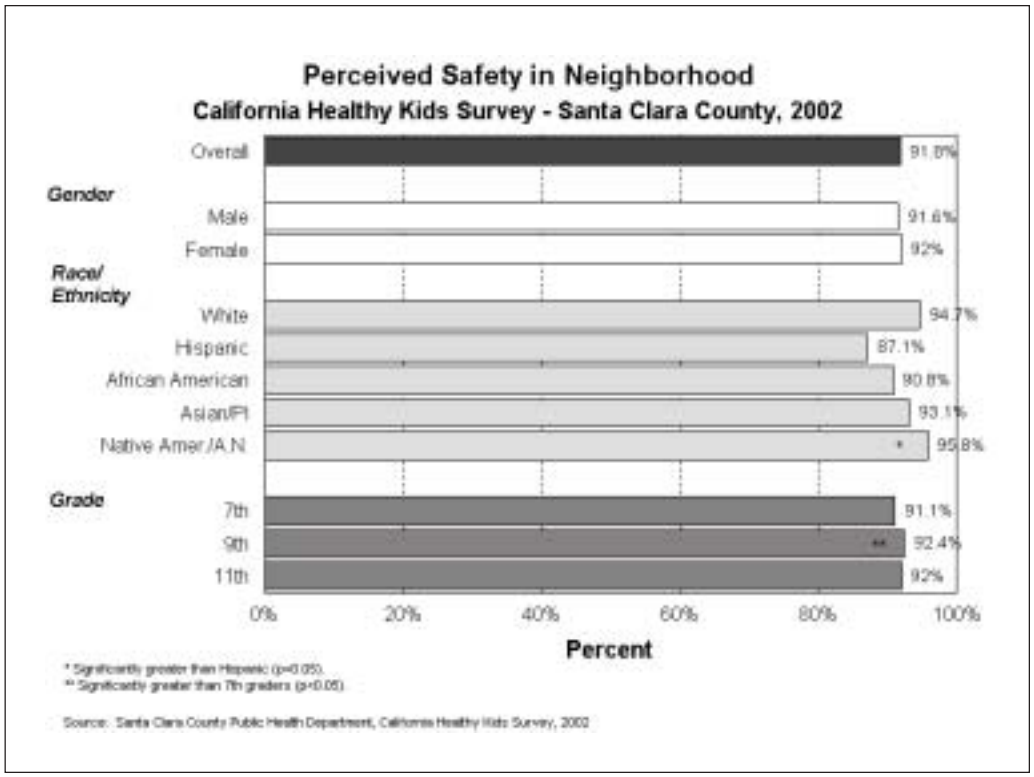
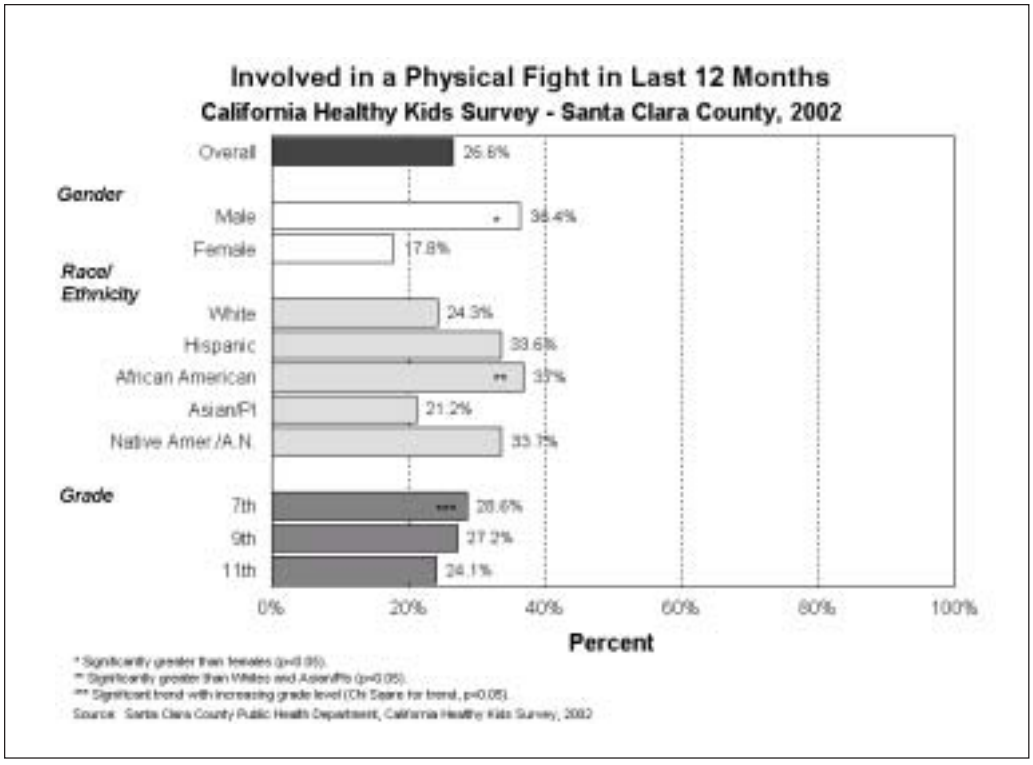


Figure 129



Neighborhood Safety continued

Figure 130

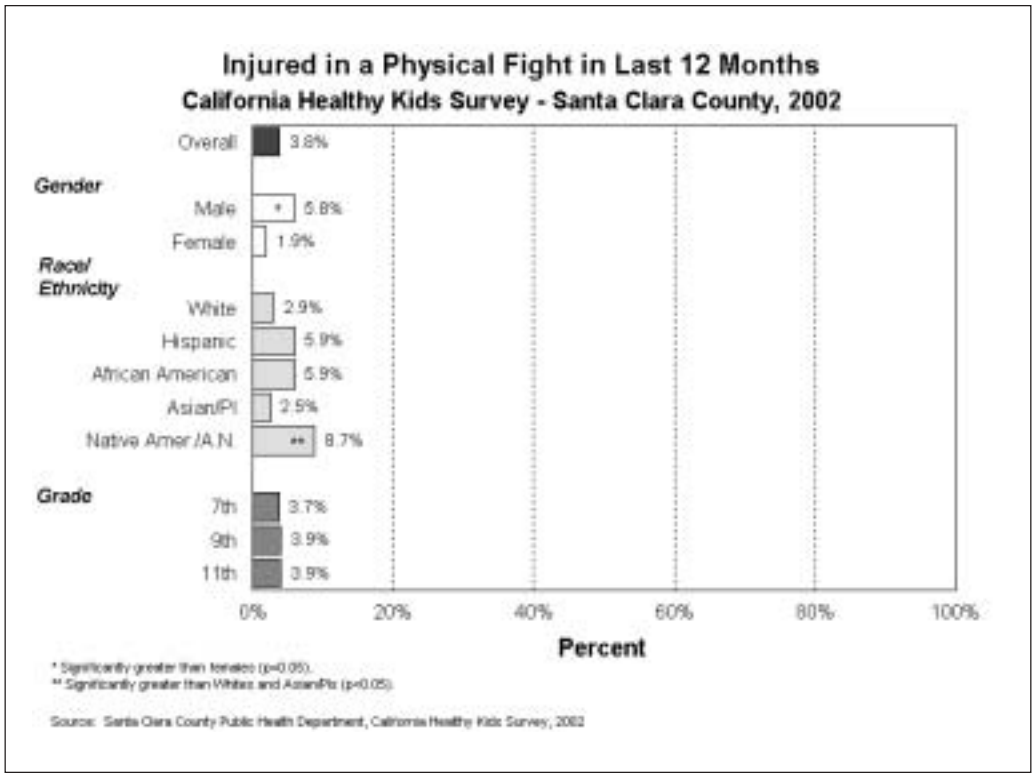
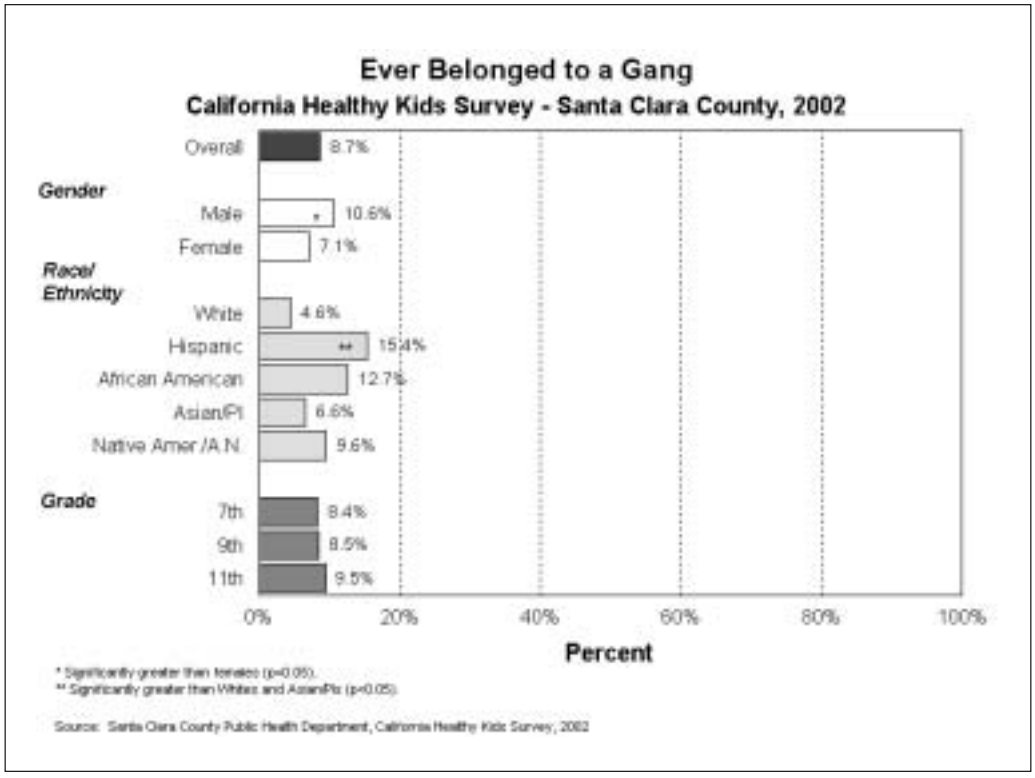
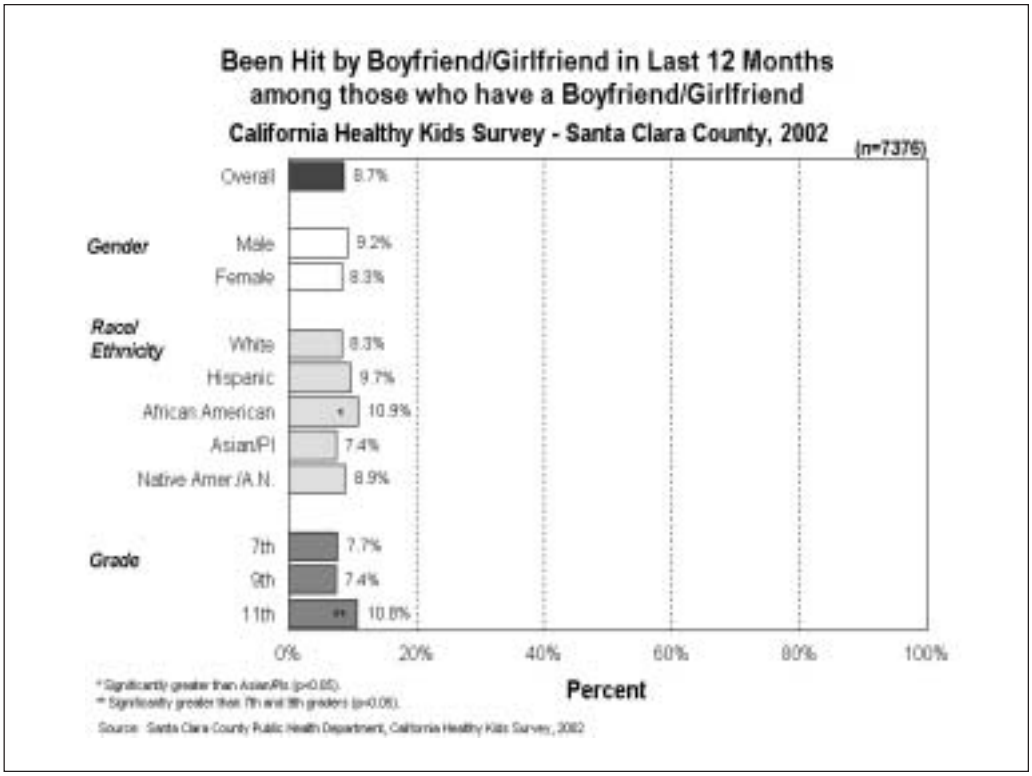


Figure 131



Neighborhood Safety continued

Figure 132



Hate Crimes & Incidents

BACKGROUND

Hatred against others is a tragic part of the nation's history, however, it is only recently that hate crimes and incident reports have been collected by government agencies.[130] Hate crimes are criminal acts against people, property, or organizations motivated by bias against the group to which they belong to or identify with, such as sexual orientation, religion, disability, race, or ethnicity. Hate incidents are biased acts against a victim or group but in a non-criminal nature. Examples of hate incidents are name calling, demonstrations, or printing materials that are intentionally designed to insult individuals or a group because of race, ethnic background, religion, national origin, sexual orientation, age, or disability.[131]

HOW ARE WE DOING?

Table 43
Rate of Hate Crime Incidents Reported
Per 100,000 Population
(All Ages)

Santa Clara County*	3.91
California*	5.78
U.S.**	3.40

* Source: California Department of Justice, Division of Criminal Justice Information Services, 2000

** Source: Federal Bureau of Investigation, Uniform Crime Reporting (UCR) Program, 2001

KEY FINDINGS

The rate of hate crime incidents reported to the California Department of Justice in Santa Clara County during 2000 was lower than reported throughout California. However, the County's rate was slightly higher than the nation's rate during the same time period.[132]

According to the Santa Clara County Network for a Hate-Free Community, the reporting of hate crimes and incidents in Santa Clara County increased dramatically after September 11, 2001. In 2002, reported hate crimes decreased from the pre-September 11 levels, but reports of hate incidents increased (Table 43).

Hate Crimes & Incidents continued

Table 44
Number of Hate Incidents and Crimes Reported in Santa Clara County

	Hate Incidents	Hate Crimes
2000	3	57
2001, pre 9/11	4	58
2001, post 9/11	71	77
2002	72	24

Source: Santa Clara County Network for a Hate-Free Community (2003).

Hate incidents reported to the Network and law enforcement in 2001 was 2500% higher than in 2000. The total number of hate crimes reported in 2001 was 281% higher than in 2000. The total number of hate incidents and hate crimes reported in 2001 was 391% higher than in 2000.[133] However, local law enforcement reported to the County's Network for a Hate-Free Community that the actual rates of hate incidents and hate crimes are higher than is reported.[134]

Registered Sex Offenders

Megan's Law is named after Megan Kanka, a seven-year-old girl who was raped and killed by a known child molester who had moved across the street from her family without their knowledge. California's Megan's Law provides the public with information on the whereabouts of serious sex offenders so community members may protect themselves and their children. The law also allows local law enforcement agencies to alert the public about high-risk sex offenders who live and are employed in the community.

As of June 7, 2002, the Megan's Law database at the Santa Clara County Sheriff's Office indicated that 3,436 registered sex offenders were living in Santa Clara County. Of these, 3,408 (99%) were males and 28 (1%) were females. Fifty-four of these sex offenders were considered "high risk." Among the registered sex offenders, 43% were White and 41% were Hispanic. These totals did not include sex offenders who were incarcerated or where county of registration was unknown. The highest numbers of sex offenders were living in the following zip codes in Santa Clara County:

Table 45
Location of Registered Sex Offenders

Zip Code	Number of Sex Offenders
95112	381
No zip code	281
95116	202
95122	180
95111	171
95127	156
95110	130
95020	117
95126	109
95050	99

Source: Megan's Law Database at the Santa Clara County Sheriff's Office (June 2002).

Juvenile Crime

Juvenile crime remains one of the most significant indicators of social breakdown. Youth who participate in criminal acts not only pose a risk to themselves, but to the community. Youth who enter the juvenile hall or probation systems may also be at risk for further offenses and felony arrests if intervention efforts are not successful. Indicators of juvenile crime in Santa Clara County include offenses and arrests, juvenile hall admissions, and youth on probation.

Juvenile Crimes/Offenses

Minors under 18 years old who are arrested for committing crimes/offenses are under the jurisdiction of the Juvenile Delinquency Courts, a division of the Superior Court of California in Santa Clara County. The Delinquency Court is responsible for the protection and safety of the public and the minor who has come in contact with the court.[135]

Crimes can be considered as felony or misdemeanor offenses, depending on the severity of the acts. A felony is a major criminal offense punishable by death or by imprisonment for more than one year in a state prison. Felony crimes include violent offenses (homicide, forcible rape, robbery, assault, and kidnapping), property offenses (burglary, theft, motor vehicle theft, forgery, and arson), drug offenses, sex offenses, and other offenses (weapons, driving under the influence, hit-and-run, escape, bookmaking, and other). A misdemeanor is a crime, other than a felony or an infraction, punishable by payment of a fine or by imprisonment not to exceed one year in the county jail. Examples of misdemeanor violations are petty theft, driving on a suspended license, vandalism, and drunk driving.[135]

The arrest rate per 100,000 juveniles in Santa Clara County for criminal offenses in 1999 to 2001 are presented in Table 45. Juvenile offense and arrest rates were similar in 1999 and 2000 then slightly decreased in 2001 for all offenses. The highest rate was property offenses, followed by violent offenses and other offenses, such as possession of weapons, driving under the influence, hit-and-run, escape, bookmaking, and other felonies. According to the California Criminal Justice Profile Report for Santa Clara County, 2,490 (84%) juvenile males and 488 (16%) juvenile females were arrested in 1999 for felonies. Juvenile arrests increased slightly in 2000 to 2,513 (81%) males and 571 (19%) females. In 2001, 2,164 (82%) juvenile males and 482 (18%) females were arrested for felonies. Of the total juvenile arrests in 2000, 23% were reported among 16-year olds, followed by 18% among 15-year olds, and 14% among 14-year olds.[136]

Overall, the juvenile felony arrest rates among Santa Clara County juveniles were similar to California's figures. Although "other offenses" were lower for the state, Santa Clara County had slightly lower rates for violent, property, drug (except in 2001), and sex offenses than reported by the state.[137]

Juvenile Crimes/Offenses continued

Table 46
Santa Clara County Felony Arrest Rate per 100,000 Juveniles

	Santa Clara County			California		
Offense Type	1999	2000	2001	1999	2000	2001
All Offenses	1644.4	1636.1	1344.5	1,776.2	1,595.0	1527.5
Violent Offenses	399.2	403.2	314.0	493.0	417.9	419.3
Property Offenses	741.6	725.2	616.9	851.7	777.4	709.9
Drug Offenses	170.6	178.2	143.3	170.8	155.6	143.1
Sex Offenses	28.7	27.6	29.0	44.1	43.9	45.1
Other Offenses	304.3	301.9	241.4	216.6	200.2	210.2

Source: State of California Department of Justice (2001).

Juvenile misdemeanor arrest rates per 100,000 were 4,552.2 in 1999 and 4,141.1 in 2000. For both years, approximately three-quarters of misdemeanor arrests were among young males. Most misdemeanor arrests reported in 1999 were for petty theft, followed by assault and battery and vandalism. In 2000, most misdemeanor arrests were for petty theft, assault and battery, and use/possession of marijuana. As observed with felony arrests, the number of misdemeanor arrests in 2000 increased as age increased among juveniles. A quarter of total juvenile misdemeanor arrests were reported among 16-year olds, followed by 20% among 15- year olds, and 16% among 14-year olds.[138]

Possession of weapons accounted for 13% of felony arrests in 1999 and 2000. Possession of weapons accounted for 0.3% of misdemeanor arrests in 1999 and 2000.[138]

Approximately 10% of felony arrests were reported for drug offenses in 1999 and 2000. Approximately 12% and 14% of misdemeanor arrests were reported for marijuana and other drug use offenses in 1999 and 2000, respectively.[138]

Juvenile Hall Admissions

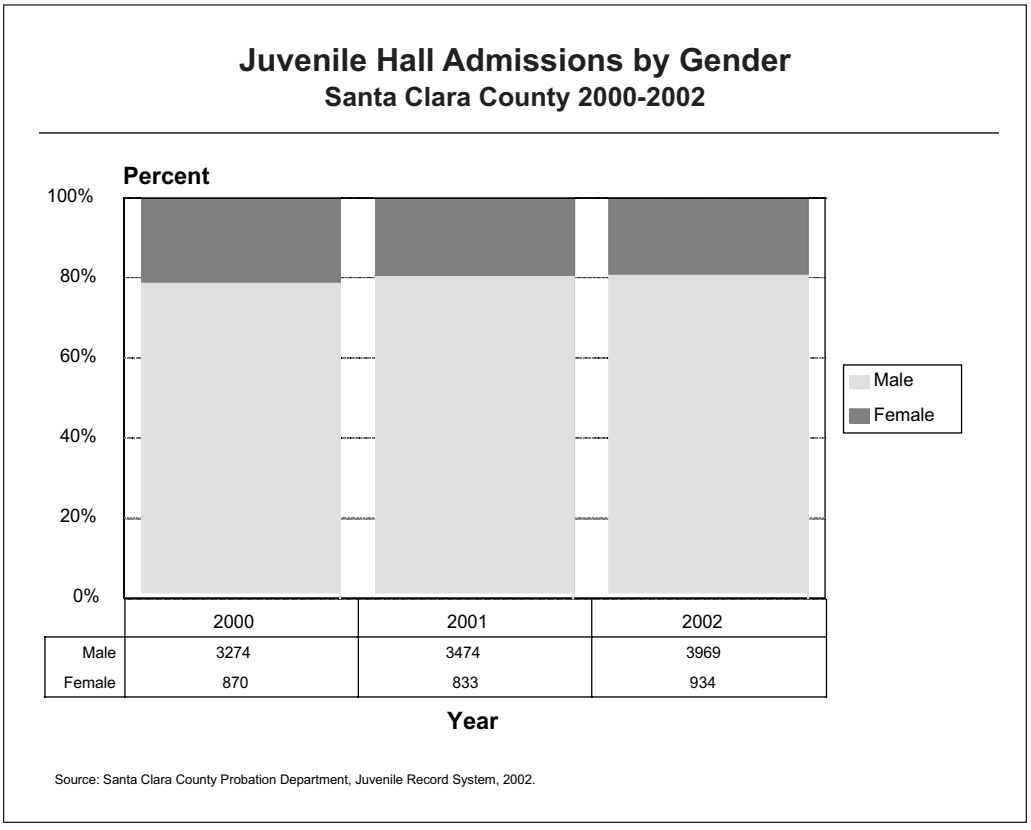
BACKGROUND

Santa Clara County Juvenile Hall provides temporary residential housing for youth awaiting adjudication or disposition from the Juvenile Courts. Services are provided to youth who are admitted to Juvenile Hall to assist with their social reintegration into the community and address their social, physical, behavioral, psychological, and emotional needs.[139]

KEY FINDINGS

From 2000 to 2002, there were a total of 13,354 youth up to 17 years old admitted in Santa Clara County's Juvenile Hall system. The total number of admissions increased slightly over the three years from 4,144 admissions in 2000 to 4,903 admissions in 2002.[140*] Among youth who were admitted, 80% were male (Figure 133). Furthermore, Hispanic/Latinos had the highest percent of admissions compared to other race and ethnic groups (Figure 134).

Figure 133

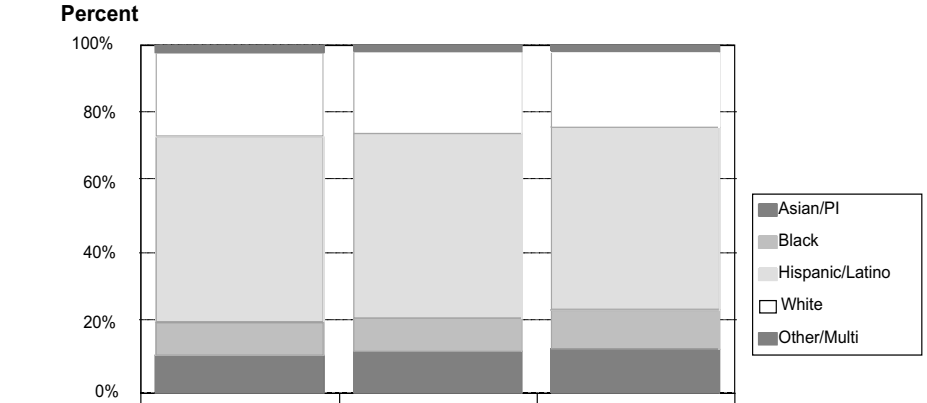


*Note: The counts of juvenile hall admissions are taken from the Santa Clara County's Enterprise Data Warehouse (EDW). These counts have not been cross-referenced for discrepancies with the source system within the Probation Department.

Juvenile Hall Admissions continued

Figure 134

Juvenile Hall Admissions by Race/Ethnicity
Santa Clara County 2000-2002



	2000	2001	2002
Asian/PI	450	520	620
Black	399	411	551
Hispanic/Latino	2209	2288	2574
White	999	1010	1068
Other/Multi	87	78	90

Year

Source: Santa Clara County Probation Department, Juvenile Record System, 2002.

Youth on Probation

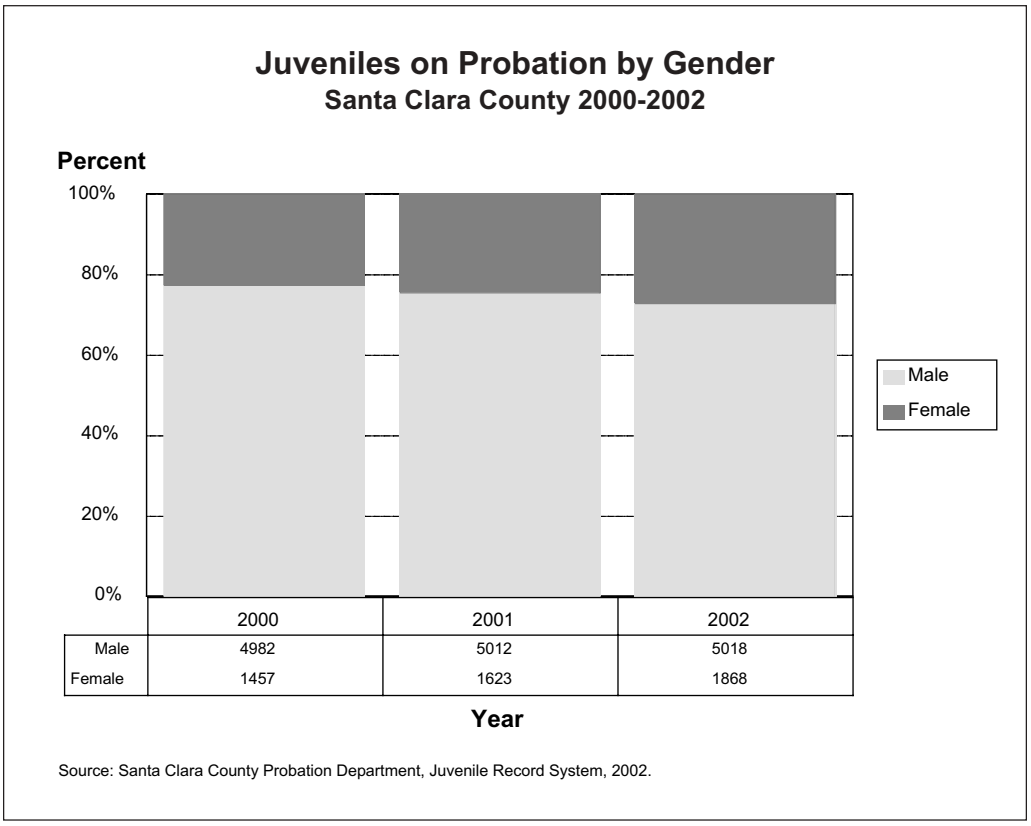
BACKGROUND

The Santa Clara County Probation Department develops, implements, and evaluates programs in collaboration with community and criminal justice agencies to help reduce crime and prevent repeat offenders. The Department provides protection to the community by holding offenders accountable through comprehensive assessment and treatment, appropriate level of supervision and sanctions, and compliance with Court orders.[141]

KEY FINDINGS

In 2002, more than 5,000 youth ages 17 and younger were on probation in Santa Clara County. Approximately 75% of these youth were male (Figure 135). In addition, 76% were between 15 and 17 years old, 22% were 12 to 14 years old, and 2% were under 12 years old. As presented in Figure 136, almost half of all youth placed on probation in 2002 were Hispanic/Latino (47%), followed by White (27%), Asian (11%), African American (8%), Pacific Islander (5%), and Other/Multiple ethnicity (2%).[142*]

Figure 135



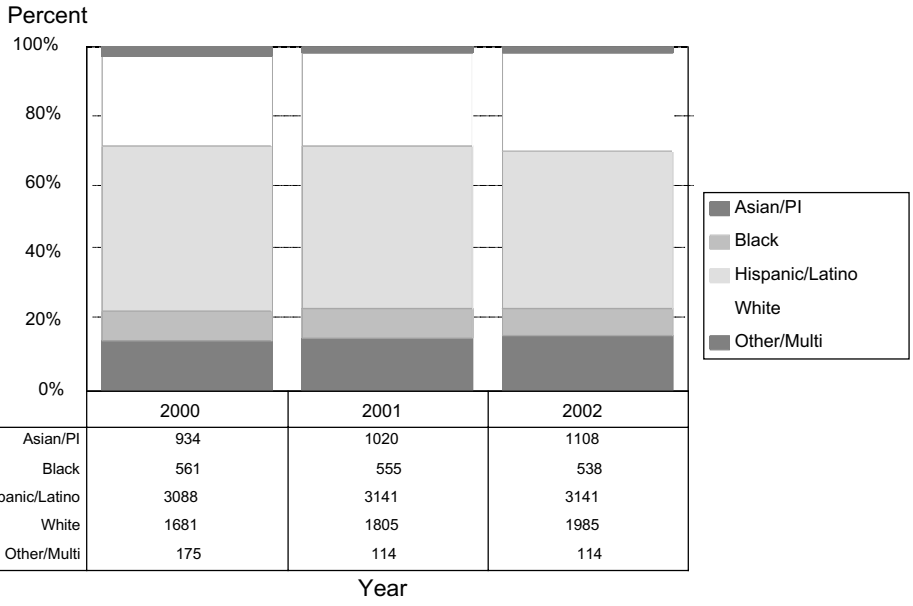
Source: Santa Clara County Probation Department, Juvenile Record System, 2002.

*Note: The counts of youth on probation are taken from the Santa Clara County's Enterprise Data Warehouse (EDW). These counts have not been cross-referenced for discrepancies with the source system within the Probation Department.

Youth on Probation continued

Figure 136

Juveniles on Probation by Race/Ethnicity
Santa Clara County 2000-2002



	2000	2001	2002
Asian/PI	934	1020	1108
Black	561	555	538
Hispanic/Latino	3088	3141	3141
White	1681	1805	1985
Other/Multi	175	114	114

Year

Source: Santa Clara County Probation Department, Juvenile Record System, 2002.

Closing Documents

Community Forum

In March 2003, community members had an opportunity to preview data prior to completion of the report and to discuss implications of the findings. Participants represented school districts, non-profit organizations, health care plans, county agencies, community clinics, and hospitals. Salient points of the report, and primary and secondary data highlights, were shared during a presentation. Participants were then able to discuss more specifically their reactions and recommendations during breakout sessions. These small group discussions were arranged by topic areas of interest: Injury & Safety, Health, Substance Abuse, Sexual Behavior, School Environment, and Family Stability.

During the Forum, the following concerns emerged:

Disparities

1. Gender (i.e., compared to boys, girls were more likely to report thinking, planning, and attempting suicide)
2. Race and ethnicity (i.e., compared to other ethnic groups, Hispanic students were more likely to report driving while drunk or riding with a drunk driver, ever smoking, ever drinking alcohol, current alcohol use, and using marijuana before age 13)
3. Grade level (i.e., a higher proportion of high school, older, students reported using tobacco, alcohol, and any other drug than the younger students)

Data gaps

1. Geographical analysis of the data would provide a more accurate picture of youth status in the County.
2. Multiple year comparisons would show trends and outcomes over time.
3. Primary data relating to elementary-aged youth would provide valuable insights.

Limitations of CHKS (source of primary data)

1. Requirement of positive parental consents may possibly skew the pool of students surveyed.
2. Private school students are not represented.

Implications

Implications of the findings include budget allocations, program design and prioritizing, policy development, and coalition building. Specifically, strengthening community partnerships and coalitions was recommended across all topic areas. Also sharing resources and expertise is especially needed in times of economic slowdowns. Last, but not least, is to shift and/or re-prioritize resources to best address disparities.

Conclusions

The information presented in this report spans a broad spectrum of issues related to the welfare of Santa Clara County's children. Across four domains—health and well-being, family stability, community safety, and school success—specific indicators were selected with an eye toward accurate and timely data that can be used for planning and action to improve the lives of children. There was an abundant amount of primary data collected with the CHKS survey, so much that not all of the analysis could be presented in the report. At the same time, gaps in information were revealed across the domains and indicators, resulting in a less than complete portrait of the county's children. The purpose of the conclusion section is to further elucidate some of the key data messages, discuss important data gaps, and suggest opportunities for addressing these findings.

Key Findings

Identifying key findings among the numerous and varied indicators is no easy task. Although readers will be drawn to different data according to their interest, 10 topic areas have been selected to highlight as key findings. Four questions guided their selection. First, do the data represent a Santa Clara County finding that has not been published elsewhere? Second, do the data reveal a disparity, either through comparison with state or national data or across subgroups within the population? Third, do the data reflect an issue that has received particular attention and/or resources within Santa Clara County? Fourth, do the data relate to an immediate critical issue within Santa Clara County?

Use of Dental Services

Access to dental services and prevention of tooth decay is a critical issue within Santa Clara County. Almost three-quarters of 3rd graders in Santa Clara County (72%) have a history of tooth decay. The national goal is to have no more than 42% of 3rd graders with a history of tooth decay.

Infant Mortality

Infant mortality is a basic indicator of access to prenatal care, nutrition, and the general health of a community. Santa Clara County's infant mortality rate is 4.6 deaths per 1,000 live births, lower than the California statewide rate of 5.4. The infant mortality rate is disproportionately high among Hispanic infants, 6.0 per 1,000 live births. The average infant mortality rate for African Americans (1996-2000) was 12.2 per 1,000 live births. An average is presented because the small numbers of African Americans in the county population lead to increased variability in individual years.

Immunization

Immunizations for infants and toddlers protect them from preventable diseases, suffering, and mortality. Additionally, the immunization status of children 0 to 2 years old is a proxy measure of young children's

access to a medical home and ongoing well-child care. In 2002, Hispanic children had the lowest percentage of immunization coverage rates (65%) compared to African American children (78%), White children (80%), and Asian/Pacific Island children (78%).

HIV/AIDS

Armed with information and education, HIV/AIDS is entirely preventable. The California Department of Education recommends that students receive HIV/AIDS education in schools. Yet, only 64% of middle school students reported that they received HIV/AIDS education in schools, substantially lower than the Healthy People 2010 objective of 95%.

Nutrition, Physical Activity, and Body Weight

Childhood overweight and obesity has emerged as a major public health problem in the nation. Good nutrition and physical activity are essential for children's growth and development and for preventing the risks that accompany overweight and obesity.

Educating school-aged children about nutrition helps establish healthful eating habits early in life. California legislators have set nutritional standards that address the availability and types of food in schools. Overall 60% of Santa Clara County's students reported eating breakfast on the day they were surveyed. White students were significantly more likely to have had breakfast than all other race/ethnic groups. When asked about the types of food they eat, 78% of all students reported eating fruits during the past 24 hours, and 81% of all students reported eating vegetables in the past 24 hours. A significantly smaller percentage of African American students reported eating fruits in the last 24 hours than other race/ethnic groups. Over 50% of the students reported consuming soda or fries at least once in the past day.

When asked how they describe their weight, one-third of high-school students reported that they were "overweight". The Healthy People 2010 Objective is to reduce the percentage of overweight students to 29%. Physical activity is a critical component of the prevention of childhood obesity as well as an important life-time behavior for the prevention of heart disease, osteoporosis, and other conditions which occur in adulthood. Approximately 67% of students reported engaging in vigorous physical activity more than 3 days per week. The Healthy People 2010 Objective is 85%.

Substance Use

Compared to California, tobacco use among youth in Santa Clara County is slightly lower. Approximately 11% of high-school students reported smoking cigarettes in the past month, compared to 15% for California. Santa Clara County has successfully surpassed the Healthy People 2010 Objective of reducing current smoking among high-school students to 16%.

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Conclusions continued

Overall 16% of Santa Clara County's high-school students reported using marijuana in the past month, slightly below the statewide proportion of 18%. The county has a far way to go to reach the Healthy People 2010 Objective of 0.7%. When asked about alcohol drinking, 10.6% of Santa Clara County's students indicated that they engaged in binge drinking. The Healthy People 2010 Objective is to reduce binge drinking to 2% among middle and high school students.

Sexual Behavior

Although teen pregnancy rates have declined over the past few years, a portion of Santa Clara County's youth reported engaging in sexual activity. Eighteen percent of Santa Clara County students reported being currently sexually active, compared to the national objective of 33% of adolescents currently sexually active. Of those Santa Clara County students who were sexually active, 24% reported using alcohol or drugs before last sexual intercourse, compared to the Healthy People Objective of 26%.

Suicide

The risk of suicide for youth is a serious concern in Santa Clara County. Among students surveyed, 21% reported that they seriously thought of committing suicide in the past, with 19.9% of them being high-school-aged. Significantly more female high-school students thought of committing suicide than their male counterparts.

Overall, 7% of middle-school students and 9% of high-school students reported having attempted suicide in the past. More female students had attempted suicide in the past than males for both age groups. Hispanics (11%) and African Americans (8%) were more likely than Whites and Asian/PIs to report having attempted suicide among middle-school students.

Violence and Abuse

Violence and abuse is a concern among homes in Santa Clara County because of the nature of threats these acts have on the welfare of families and children. In 2001, the rate of domestic violence related calls per 1,000 residents was 3.75 in the county, slightly lower than California's rate of 5.70. Furthermore, there were 1,866 Emergency Protective Restraining Orders issued in the county in 2000, with about half involving children at home.

Although the incidence per 1,000 children of child abuse cases in the County has been lower than in California, the numbers did not improve from 1999 to 2000. The incidence of child abuse in Santa Clara County was 36 and 37 during 1999 and 2000, respectively, versus 62 (1999) and 65 (2000) in the state. In 2001, most child abuse cases were among children between 5 to 14 years of age. Of all ethnicities, Hispanics comprised the largest percent of child abuse cases.

Academic Performance and Expenditure

Recent years have witnessed a heightened emphasis on educational standards and testing in California's public schools. The Academic Performance Index (API) is a school's measure of their student's performance on the STAR exam (SAT9). Each year, schools are given a target API score with incentives for achieving the score. In Santa Clara County, 78% of schools in the 2000-2001 school year met their school-wide growth target, compared to 70% of schools for California as a whole.

California's average per pupil expenditure ($5462) is substantially below the national average ($6911). Santa Clara County's average per pupil expenditure ($6521) exceeds the state average but falls short of the national average.

Violence and Crimes

Safety on school campuses and in the community is a concern within schools, families, and neighborhoods. Overall 7% of 11th grade students reported carrying a weapon on school property. The rate of felony arrests among juveniles in 2001 was 1,345 per 100,000 youth.

Data Gaps

The collaboration between the Public Health Department and Cross Systems Evaluation has resulted in access to more data and better interpretation of data that are available. Yet, considerable data gaps remain. The gaps fall under two broad categories: content and analysis.

Content Gaps

Data were missing or insufficient for the following topics related to the well-being of children.

1. County-wide breastfeeding rates
2. County-wide mental health prevalence rates for children
3. Behavior risk data for elementary age children and private-school students
4. Resilience data, including peer and child-adult relationships
5. Foster care indicators
6. Child abuse indicators

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Conclusions continued

Analysis Gaps

County-wide data are an important foundation to understanding the status of our children's well-being, but county-wide statistics can mask underlying disparities across geographic, ethnic/racial, age, gender, and other distinctions. Consequently, continued effort to analyze and present information that can assist in better understanding these disparities is essential. The following additional analyses were identified as data gaps.

1. Geographical analysis by school district, neighborhood, city, poverty zones, etc.

2. Further breakdown of ethnic/racial categories, particularly in the Asian/Pacific Island category

3. Multiple year comparisons of data

Next Steps

Transforming Data Into Action

The purpose of this report is to provide meaningful, accurate, and timely data to community members, organizations, institutions, and policy makers to be used for improving the lives of Santa Clara County's children and youth. The information can be used for strategic planning, resource allocation, program design, evaluation, policy development, and coalition building.

The 10 key findings can be positively impacted by prevention and early intervention strategies aimed at eliminating disparities and, where applicable, achieving the Healthy People 2010 Objective. Given the current economic conditions and reductions in governmental and private funding for local programs, community partnerships are increasingly important for closing gaps in health status, school success, family stability, and community safety. The report can be a catalyst for the community to apply best practices to any and all of the key findings.

Data Gaps and Future Reports

This is the second comprehensive children's report the Public Health Department has produced as part of its role in monitoring the health status of Santa Clara County's residents. As a result of the partnership between Cross Systems Evaluation and the Public Health Department, this report extends beyond the first publication to address topics outside of the health domain. Planning is underway to produce a third report in the fall of 2004, with CHKS data collection occurring in fall 2003. The goal is to continue to expand the circle of participants in the development of the report in order to fill data gaps and provide increasingly rich information. Efforts are underway to collect and analyze the CHKS data geographically. Additionally, the CHKS resiliency module will be implemented and the data will be analyzed and presented. Finally, multiple year comparisons will be available in the subsequent report, providing us with a better understanding of actual trends.

Glossary

Adjusted Odds Ratios: Measure of association derived from the ratio of the odds of exposure among the cases to the odds of exposure among noncases, adjusted by taking into account the effect of other exposures.

Adoption: a legal process that permanently gives parental rights to adoptive parents.

Affordable Housing: housing that does not cost more than 30% of a family's income. (U.S. Department of Urban Development, 2003).

AIDS: Acquired immunodeficiency syndrome, the most severe phase of infection with the human immunodeficiency virus (HIV). Persons infected with HIV are said to have AIDS when they get certain opportunistic infections or when their CD4+ cell count drops below 200. (U.S. Department of Health and Human Services, 2000).

Arrearage: An amount of an obligation which is past.

Asthma: A lung disease characterized by airway constriction, mucus secretion, and chronic inflammation, resulting in reduced airflow and wheezing, coughing, chest tightness, and difficulty breathing. (Department of Health and Human Services, 2000).

Average Daily Attendance: The total days of student attendance divided by the total days of instruction. (California Department of Education, 2002).

Average Household Size: The total population in households divided by the total occupied households. (US Census Bureau, 2000).

Binge Drinking: The National Household Survey on Drug Abuse defines binge drinking as drinking five or more drinks on the same occasion on at least one day in the past 30 days. The Monitoring the Future Study defines binge drinking as drinking five or more drinks on the same occasion during the past two weeks. (U.S. Department of Health and Human Services, January 2000).

CalWORKS: a state welfare program that provides cash aid and services to eligible needy families with children, such as housing, food, utilities, clothing, or medical care. (California Department of Social Services, 2001).

Cancer: A term for diseases in which abnormal cells divide without control. Cancer cells can invade nearby tissue and can spread through the bloodstream and lymphatic system to other parts of the body. (U.S. Department of Health and Human Services, January 2000).

CDC: The Centers for Disease Control and Prevention, which is recognized as the lead federal agency for protecting the health and safety of people (at home and abroad), providing credible information to enhance health decisions, and promoting health through strong partnerships. The CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States. (CDC, 2002).

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Glossary continued

Child Abuse: Physical (shaking, hitting, beating, burning, or biting a child); emotional (constantly blaming or putting down a child; excessive yelling, or shaming); or sexual (incest, any forced sexual activity, or exposure to sexual stimulation not appropriate for the child's age). Neglect can also constitute child abuse and is defined as a pattern of failure to provide for the child's physical needs (food, clothing, shelter, and medical care); or a pattern of failure to provide for the child's emotional needs, such as affection, attention, and supervision. (Medline Plus Health Information, 2003).

CHKS: California Healthy Kids Survey

Contraception (Birth Control): The means of pregnancy prevention. Methods include permanent methods (vasectomy for men and tubal ligation for women) and temporary methods (for example, hormonal implant, injectable, birth control pill, emergency contraceptive pills, intrauterine device, diaphragm, female condom, male condom, spermicidal foam/cream/jelly, sponge, cervical cap, abstinence, natural family planning, calendar rhythm, and withdrawal). (U.S. Department of Health and Human Services, 2000).

Dental Caries (Dental Decay, Tooth Decay or Cavities): An infectious disease that results in de-mineralization and ultimately cavitation of the tooth surface if not controlled or remineralized. Dental cavities may be either treated (filled) or untreated (unfilled). (U.S. Department of Health and Human Services, 2000).

Disability: General term used to represent the interactions between individuals with a health condition and barriers in their environment. The term disability is operationalized as self-reported activity limitations or use of assistive devices or equipment related to an activity limitation. (U.S. Department of Health and Human Services, 2000).

Domestic Violence: a pattern of abuse in an intimate relationship where one partner controls the other through force, intimidation, or the threat of violence. These abusive relationships are based on the belief that one person has the right to control another. (County of Santa Clara, Domestic Violence Unit, 2003).

Extrapulmonary: Outside of the lungs or having no relation to the lungs.

Family Planning: The process of establishing the preferred number and spacing of one's children, selecting the means to achieve the goals, and effectively using these means. (U.S. Department of Health and Human Services, 2000).

Federal Poverty Level (FPL): In February of each year, the Federal Government releases an official income level for poverty called the Federal Poverty Guidelines, and often informally referred to as the "Federal Poverty Level". The benefit levels of many low-income assistance programs are based on these poverty figures. The Santa Clara County Public Health Department used the 1999 Department of Health and Human Services Poverty Guidelines to describe the 100% Federal Poverty Level. Multiplying the numbers by two provided the 200% Federal Poverty Level Guidelines.

1999 HHS Poverty Guidelines			
Size of Family Unit	**48 Contiguous States and D.C.**	**Alaska**	**Hawaii**
1	$ 8,240	$10,320	$ 9,490
2	11,060	13,840	12,730
3	13,880	17,360	15,970
4	16,700	20,880	19,210
5	19,520	24,400	22,450
6	22,340	27,920	25,690
7	25,160	31,440	28,930
8	27,980	34,960	32,170
For each additional person, add:	2,820	3,520	3,240

Source: Federal Register, March 1999, as cited by the U.S. Department of Health and Human Services website, n.d.

Felony: A major criminal offense punishable by death or by imprisonment for more than one year in a state prison. (Santa Clara County, Office of the Public Defender, 2003).

Foster Family Home: a private residence (apartment or house) that has been licensed to serve as a temporary setting for children who are dependents of the courts. (Santa Clara County Social Services Agency, 2003).

Hate Crimes: Certain criminal acts, when committed because of bias against the victim or a group to which the victims perceived to belong. These groups include those crimes committed against people because of their real or perceived gender, religion, disability, race, ethnicity, or sexual orientation. (Hate-Crime Network, n.d.).

Hate Incidents: Hate-motivated (bias) incidents that are expressed by hostility, hatred, or negative attitudes against a person or property because of the victim's race, sexual orientation, disability, religion, gender, ethnicity, or sexual orientation. Examples of hate incidents include threatening phone calls, hate mail, physical assaults, and vandalism, as well as non-criminal actions that are motivated by bias, such as non-threatening name-calling or using racial slurs. (Hate-Crime Network, n.d.).

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Glossary continued

Health: A state of physical, mental, and social well-being and not merely the absence of disease and infirmity. (World Health Organization, 2002).

Health Care Coverage: Refers to the type of health care coverage (whether paid by public or private sector) of those individuals who report only one type of health care coverage, or the health care coverage used to pay most of the cost of medical care among those individuals who reported that they had more than one plan. Health care coverage is what an individual uses to cover most of the cost of medical care. It also includes referral or linkage to assure access to health service. (U.S. Department of Health and Human Services, 2000).

Health Insurance: Any type of third party payment, reimbursement, or financial coverage for an agreed-upon set of health care services. Includes private insurance obtained through employment or purchased directly by the consumer, or health insurance provided through publicly funded programs, including Medicare, Medicaid, CHAMPUS/CHAMPVA, or other public hospital or physician programs. (U.S. Department of Health and Human Services, 2000).

Healthy Birth Weight: A birth weight of 2,500 grams or more (about 5.5 pounds). (U.S. Department of Health and Human Services, 2000).

Healthy People 2010 Objectives: The Healthy People Year 2010 Objectives are a national set of benchmarks developed by a consortium of groups in association with the US Department of Health and Human Services. Objectives were developed for some special populations based on baseline national statistics. (U.S. Department of Health and Human Services, January 2000). On a cautionary note, since the racial/ethnic composition of Santa Clara County is different than the US, both Y2000 and Y2010 objectives may not always provide appropriate measures for our county. Not all indicators presented in this report were compared to Healthy People 2010 Objectives; a number of indicators did not have a corresponding objective; and/or the comparison was not appropriate for the population that was presented. (U.S. Department of Health and Human Services, 2000).

HIV (Human Immunodeficiency Virus): A virus that infects and takes over certain cells of the immune system that are important in fighting disease. (U.S. Department of Health and Human Services, January 2000).

Homelessness: A person is considered homeless when he or she lacks a fixed, regular, and adequate nighttime residence. (U.S. Code, 1987).

ICD-9 and ICD-10: An abbreviation for the International Classification of Diseases, 9th Revision and 10th Revision. The ICD system is a statistical classification coding system to categorize mortality information. The ICD-9 classification system was revised, and ICD-10 were implemented for mortality data in 1999. (CDC, 2003).

Infant Mortality Rate: the proportion (number of deaths per 1,000 live births) of babies who are born in a given year and die within their first year of life. (U.S. Department of Health and Human Services, 2000).

Injury: Unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as heat or oxygen. (U.S. Department of Health and Human Services, 2000).

Living Wage: The amount of income required for a family to reach self-sufficiency without public or private assistance. (Bay Area Alliance for Sustainable Communities, 2003).

Low Birth Weight: An infant with a birth weight less than 2,500 grams. (U.S. Department of Health and Human Services, 2000).

Low Income: Low income is defined by the Healthy People Year 2000 Objectives as annual family income less than $10,000 or annual family income less than $20,000 depending on the objective. This concept is different from the threshold poverty level established by the federal government that takes into account the size of the family when examining income. Neither definition of low income adjusts for the cost of living in a particular area. (U.S. Department of Health and Human Services, 2000).

Median Family Income: The median family income is a median income figure for all family sizes. The U.S. Department of Housing and Urban Development calculates these figures for metropolitan and nonmetropolitan area using the Fair Market Rent (FMR) area definitions applied in the Section 8 Housing Choice Voucher Program. The estimated median family income for the United States for FY 2003 is $56,500. (U.S. Department of Housing and Urban Development, 2003).

(Median) Household Income: Household income is the sum of money income received in the previous calendar year by all household members 15 years old and over, including household members not related to the householder, people living alone, and others in nonfamily households. (U.S. Census Bureau, 1997).

Median Price of Home: The price that is midway between the least expensive and the most expensive homes sold in an area during a given period of time. (Annual Bulletin Tracking Housing Costs in King County, 2002).

Medi-Cal: Medi-Cal is California's state Medicaid program, providing health care services for low-income families and individuals who lack other health insurance. Medi-Cal is jointly funded by the state and federal governments. It is the primary source of health care for many children, elderly, blind, and disabled. (California Department of Health Services, 2002).

Misdemeanor: A crime, other than a felony or an infraction, punishable by payment of a fine or by imprisonment not to exceed one year in the county jail. (Santa Clara County Office of the Public Defender, 2003).

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Glossary continued

Moderate Physical Activity: Participation in physical activity or exercise at least 30 minutes per session 5 or more days per week that does not result in breathing hard or sweating. (U.S. Department of Health and Human Services, 2000).

n.d.: No date (listed in the Reference section for sources retrieved from the internet with no date indicated).

Neonatal Mortality: Infant death at full-term birth (0 days old) to 27 days old. (U.S. Department of Health and Human Services, 2000).

Neural Tube Defects (NTDs): A set of birth defects that result from failure of the neural tube to close in utero. Two of the most common NTDs are anencephaly (absence of the majority of the brain) and spina bifida (incomplete development of the back and spine). (U.S. Department of Health and Human Services, 2000).

Overweight: Excess body weight. A Body Mass Index (BMI) between 25 and 29.9 is considered overweight. (U.S. Department of Health and Human Services, 2000).

Per Capita Income: Income per person in a population. Per capita income is often used to measure a country's standard of living. (U.S. Census Bureau, 2000).

Perinatal: Of, relating to, or being the period around childbirth, especially the five months before and one month after birth. (U.S. Department of Health and Human Services, 2000).

Perinatal Mortality: Infant death at 20 or more weeks gestation. (U.S. Department of Health and Human Services, 2000).

Per Pupil Expenditure: Per-pupil expenditure is the total direct cost of education divided among pupils in the public schools for a given year. Included in the cost are teacher salaries and benefits, classroom materials and supplies, and other equipment or services used in the classroom. (Sacramento County Children's Report Card, 2000).

Poverty: Using a set of money income thresholds that vary by family size and composition, poverty is defined when a family's total income is less than that family's threshold. Poverty is not defined for people in military barracks, institutional group quarters, or for unrelated individuals under age 15 (such as foster children). (U.S. Census Bureau, 2000).

Prenatal Care: Care provided to pregnant women to prevent complications and reduce incidence of maternal and infant mortality. It typically includes three components: risk assessment, treatment for medical conditions or risk reduction, and education. (U.S. Department of Health and Human Services, 2000).

Prevalence: The number of events, e.g., instances of a given disease or other condition, in a given population at a designated time. (Last et al for the International Epidemiological Association, Inc., 1995)

Quality of Life: Quality of life reflects a general sense of happiness and satisfaction with our lives and environment. General quality of life encompasses all aspects of life, including health, recreation, culture, rights, values, beliefs, aspirations, and the conditions that support a life containing these elements. Health-related quality of life reflects a personal sense of physical and mental health and the ability to react to factors in the physical and social environments. Health-related quality of life is more subjective than life expectancy and therefore can be more difficult to measure. Some tools have been developed to measure health-related quality of life. (U.S. Department of Health and Human Services, 2000).

Race/Ethnicity: Different categories are used when referring to race or ethnicity. Assumptions regarding these categories change over time in response to greater awareness of the meaning and relevance of race, ethnicity and geographical origin. The following are race/ethnicity categories as recommended by Office of Management and Budget (OMB), however in this report, ethnic groups represented are Whites, Hispanics, Asian/Others, and African Americans:

> American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
>
> Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
>
> Black, African American: A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
>
> Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Categorized under "Asian/Other" in this report.
>
> Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino".
>
> Other: Other and refused to state/unknown race.
>
> White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

(Office of Management and Budget, 2000)

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Glossary continued

Rate: The basic measure of disease occurrence that most clearly expresses the probability of risk of disease in a defined population over a specified period of time. A rate is defined as a number of events divided by population at risk. (U.S. Department of Health and Human Services, 2000).

SCC: Santa Clara County

Sexual Assault: Unwanted sexual contact or forced sex that includes oral, anal, or vaginal intercourse in situations when threats, physical force, or a weapon was used; also includes situations when a person was unable to give consent due to age, drugs, alcohol, sleep, or mental disability. (U.S. Department of Health and Human Services, 2000).

Substance Abuse: The problematic consumption or illicit use of alcoholic beverages, tobacco products, and drugs, including misuse of prescription drugs. (U.S. Department of Health and Human Services, 2000).

Wage Assignments: Court-ordered deductions from wages of non-custodial parents to provide child support. (Santa Clara County Department of Child Support Services, 2001).

Very Low Birth Weight: An infant with a birth weight less than 1,500 grams or about 3.3 pounds. (U.S. Department of Health and Human Services, 2000).

Vigorous Physical Activity: Participation in physical activity or exercise resulting in sweating or breathing hard, that promotes cardiorespiratory fitness, 3 or more days per week for 20 or more minutes per occasion. (U.S. Department of Health and Human Services, 2000).

Endnotes

1. U.S. Census Bureau, United States Department of Commerce. (n.d.). State and county quick facts. Retrieved May 16, 2003, from http://quickfacts.census.gov/qfd/states/06/06085.html

2. California Department of Finance, Demographic Research Unit. (2002). Reports and research papers. Retrieved May 16, 2003, available from http://www.dof.ca.gov/html/demograp/repndat.htm

3. Joint Venture Silicon Valley Network. (2003). Joint Venture's 2003 index of Silicon Valley: Measuring progress toward the goals of Silicon Valley 2010. Santa Clara County, California. Retrieved April 20, 2003 from http://www.jointventure.org/2003index/2003index.pdf

4. Santa Clara County Office of Education. (2001). Statistical Report for the school districts of Santa Clara County: Year ending June 30, 2001. Santa Clara County: California

5. U.S. Department of Labor, Bureau of Labor Statistics. Glossary. Retrieved on March 12, 2003, from http://www.bls.gov/bls/glossary.htm#U

6. Silicon Valley/San Jose Business Journal. (2003). Federal Reserve: Bay Area Joblessness is deeper, longer. Retrieved on May 20, 2003, from http://sanjose.bizjournals.com/sanjose/stories/2003/02/17/daily75.html

7. California Employment Development Department, Labor market information. Labor Force & Unemployment Data. (2000). Retrieved on May, 20, 2003, available from http://www.calmis.ca.gov/htmlfile/subject/lftable.htm

8. Association of Bay Area Governments. (n.d.). City, County and Census Tract Forecasts 2000-2025 [overview]. Retrieved on February 5, 2003, from http://www.abag.ca.gov/abag/overview/pub/p2002/summary.html

9. U.S. Census Bureau, Poverty 2001. (2002). Retrieved February 4, 2003, from http://www.census.gov/hhes/poverty/threshld/thresh01.html

10. U.S. Census Bureau, (2000). Census 2000 summary file Santa Clara County. Retrieved on February 6, 2003, from http://factfinder.census.gov/bf/_lang=en_vt_name=DEC_2000_SF3_U_DP3_geo_id=05000US06085.html

11. California Employment Development Department, Labor Market Information. (2000). 2000-Census demographic profile, Santa Clara County. Retrieved May 16, 2003, available from http://www.calmis.cahwnet.gov/file/Census2000/santcDP2000.pdf

12. Bay Area Alliance for Sustainable Communities. (2003, January). Bay area indicators: Measuring progress towards sustainability. Retrieved on May 16, 2003, from http://www.bayareaalliance.org/indicators.pdf

13. Employment Development Department, Labor Market Information. Industry Trends and Outlook, 1999-2006 Santa Clara county. Retrieved on February 4, 2003, from http://www.calmis.cahwnet.gov/file/occproj/santcf&g.htm

14. California Department of Education, Educational Demographics Unit, 2002. Selected County Data- Santa Clara for the Year 2001-2002. Retrieved May 20, 2003 from http://data1.cde.ca.gov/dataquest/Cbeds2.asp?FreeLunch=on&cChoice=CoProf1&cYear=2001-02&TheCounty=43%2CSANTA%2CCLARA&cLevel=County&submit1=Submit

15. U.S. Census Bureau, Supplementary Survey (2000). Demographics Santa Clara County [table]. Retrieved on February 4, 2003, from http://www.census.gov/acs/www/Products/Profiles/Single/2000/C2SS/Tabular/050/05000US060851.htm

continued next page…

Endnotes continued

16. City of San Jose Planning Office. (n.d.). Demographic trends census brief: Household size. Retrieved on February 4, 2003, from http://www.ci.san-jose.ca.us/planning/sjplan/data/Census_2000/briefs/household.html

17. Santa Clara County Association of Realtors. (2002). Market Statistics. MLS activity report in Santa Clara Valley, January 2003. Retrieved January 29, 2003, from http://www.sccaor.com/buy_sell/resources/mkt_stats/trends_main.htm

18. Real Estate News, RIS Media. (2003). California median price increased 20.2% in December. Retrieved April 8, 2003, from http://www.rismedia.com/index.php/article/articleview/3043/1/1/)

19. Silicon Valley/San Jose Business Journal (2002, August 8). California's housing affordability rate plummets. Retrieved February 4, 2003, from http://sanjose.bizjournals.com/sanjose/stories/2002/08/05/daily46.html

20. California Association of Realtors. (2002). What's new. Retrieved May 16, 2003, available from http://www.car.org/index.php?id=Mw==

21. Silicon Valley/San Jose Business Journal (2002). Firms predict apartment rents to stall. Retrieved May 16, 2003, from http://sanjose.bizjournals.com/sanjose/stories/2002/02/11/story3.html

22. Realfacts. (2003, January 24). Silicon Valley leads in declining rents. Retrieved January 28, 2003, from http://www.realfacts.com/427103.html

23. National Coalition for the Homeless. (n.d.). Facts about homelessness. Retrieved May 16, 2003, available from http://www.nationalhomeless.org/facts.html

24. Housing Trust of Santa Clara County. (n.d.). Issues on affordable housing in Santa Clara County. Retrieved January 26, 2003, from http://www.housingtrustfund.org/overview.html

25. Community Benefits Coalition Hospital Council of Northern and Central California, Santa Clara Section (2001, August). 2001 Community assessment: Health and quality of life in Santa Clara County.

26. California Department of Motor Vehicles, Licensing Operations Division, Research & Development Branch. (2002). Estimated fee paid vehicle registration by County, January 1 through December 31, 2001. Sacramento: California

27. U.S. Bureau of the Census, Decennial Censuses –1960-2000. MTC estimates of averages for 3+ vehicle household category for 1960, 1970, 1980, and 2000 [table]. Retrieved on February 5, 2003, from http://www.mtc.dst.ca.us/datamart/census/dp234/HHVehicles19602000.htm

28. Metropolitan Transportation Commission. (n.d.). Average travel time to work- 1980-2000 Decennial census. Retrieved on February 5, 2003, from http://www.mtc.dst.ca.us/datamart/census/dp234/Commutetime19802000.htm

29. U.S. Bureau of the Census, Decennial Censuses –1980-2000. Workers by Means of Transportation to Work 1980-2000. Retrieved on February 5, 2003 http://www.mtc.dst.ca.us/datamart/census/dp234/Means19802000.htm

30. Brown, E.R., Ponce, N., Rice, T., & Lavarreda, S.A. (2000, June). The state of health insurance in California: Findings from the 2001 California health interview survey. Los Angeles, CA: UCLA Center for Health Insurance Policy Research

31. Children's Health Initiative. (2003). Retrieved on March 5, 2003, from http://www.chikids.org/index.html

32. American Academy of Pediatrics. (2003). Is your child medically up to date? Retrieved May 19, 2003, from http://www.aap.org/advocacy/releases/bfdoctor.htm

33. U.S. Department of Health and Human Services. (2000). Oral Health in America: A Report of the Surgeon General-- Executive Summary. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health

34. National Governors Association and NGA Center for Best Practices. (n.d.). Children's oral health. Retrieved May 19, 2003, from http://www.nga.org/center/topics/1,1188,C_CENTER_ISSUE^D_683,00.html

35. The Health Trust. (2001). Oral health status of children in Santa Clara county: Results of the Health Trust 2001 needs assessment. Retrieved on October 30, 2002, available from http://www.healthtrust.org/about/about-pubs.cfm

36. U.S. Department of Health and Human Services. (2000, November). Healthy People 2010. 2nd ed. With Understanding and improving health and objectives for improving health. 2 vols. Washington, DC: U.S. Government Printing Office

37. Centers for Disease Control, National Center for Health Statistics. (n.d.). Vital statistics. Retrieved May 16, 2003, available form http://www.cdc.gov/nchs/

38. California Department of Health Services, Maternal and Child Health Branch. (2002). California maternal and child health data book, May 2002. [Data file]. Retrieved January 27, 2003, available from http://www.mch.dhs.ca.gov/epidemiology/MaternalChildDataBook.htm

39. California Birth Defect Monitoring Program. (2003, May). Preventing birth defects through research. Retrieved May 16, 2003, from http://www.cbdmp.org/index.htm

40. Santa Clara County Public Health Department. (2003). Behavior risk factor survey, 2000. Retrieved May 16, 2003, available from http://www.sccgov.org/content/0,4745,chid%253D186281%2526ccid%253D186410,00.html

41. Centers for Disease Control and Prevention, Lead Poisoning. (n.d.). CDC lead fact sheet. Retrieved on May 20, 2003, available from http://www.cdc.gov/nceh/lead/about/about.htm

42. Santa Clara County Public Health Department, Childhood Lead Poisoning Prevention Program. (2003). Blood Lead Screening Policies for Health Care Providers. Retrieved January 27, 2003, from http://www.sccgov.org/scc/assets/docs/186244provider7_01.pdf

43. Centers for Disease Control. (1999). Achievements in public health, 1900-1999 impact of vaccines universally recommended for children – United States, 1990-1998 (MMWR Weekly, April 2, 1999/ 48(12); 243-248). Retrieved April 7, 2003 from www.cdc.gov/epo/mmwr/preview/mmwrhtml/00056803.htm).

44. National Partnership for Immunization. (2001).The value of vaccines (brochure vol. 1, issue 2). Retrieved April 7, 2003 from http://www.partnersforimmunization.org/NPI_Bulletin2.pdf

45. California Department of Health Services, Immunization Branch. (n.d.). Immunization levels in childcare and schools. Retrieved May 16, 2003, available from http://www.dhs.cahwnet.gov/ps/dcdc/izgroup/levels.htm

46. Santa Clara County Public Health Department, Emergency Medical Services Agency. (2000, June). Annual trauma systems report, 1999. Santa Clara County, California: Santa Clara County Valley Health & Hospital System.

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Endnotes continued

47. National Cancer Institute. (n.d.). Dictionary. Retrieved on May 20, 2003, from http://cancer.gov/dictionary/db_alpha.aspx?expand=C

48. National Cancer Institute. (2002). Cancer Facts. Retrieved on May 20, 2003, from http://cis.nci.nih.gov/fact/6_40.htm

49. CDC, National Center for Environmental Health. (2002, November). Asthma's impact on children and adolescents. Retrieved May 16, 2003, from http://www.cdc.gov/nceh/airpollution/asthma/children.htm

50. Santa Clara County Public Health Department. (2003). HIV and AIDS registry, 2001.

51. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for HIV, STD, and Tuberculosis Prevention. (2002, January). Questions and answers about TB . Retrieved May 16, 2003, from http://www.cdc.gov/nchstp/tb/faqs/pdfs/qa.pdf

52. CDC, National Center for Infectious Disease. (2003, April). Viral hepatitis B [fact sheet]. Retrieved May 16, 2003, from http://www.cdc.gov/ncidod/diseases/hepatitis/b/fact.htm

53. U.S. Department of Health and Human Services. (2003). The surgeon general's call to action to prevent and decrease overweight and obesity, 2001. Retrieved May 16, 2003, available at http://www.surgeongeneral.gov/topics/obesity/calltoaction/toc.htm

54. CDC, National Center for Chronic Disease Prevention and Health Promotion. (1999, November). A report of the Surgeon General: Physical activity and health-Adolescents and young adults. Retrieved May 16, 2003, available from http://www.cdc.gov/nccdphp/sgr/adoles.htm

55. California Department of Education. (2002, December). State study proves physically fit kids perform better academically [news release]. Retrieved May 23, 2002, from http://www.cde.ca.gov/news/releases2002/rel37.asp

56. California Department of Education. (n.d.). Physical fitness test (PFT). Retrieved May 16, 2003, available from http://www.cde.ca.gov/statetests/pe/pe.html

57. California Department of Education, Standards and Assessment Division, (2003). 2001-2002 California physical fitness results, Santa Clara County [table]. Retrieved May 16, 2003, available from http://data1.cde.ca.gov/dataquest/

58. California Department of Education. (2003). National school lunch program. Retrieved May 16, 2003, from http://www.cde.ca.gov/nsd/snp/lunch.htm

59. Project LEAN. (n.d.). 2000 California fast food survey. Retrieved May 16, 2003, available from http://www.californiaprojectlean.org/consumer/hsffsurvey.html

60. California Food Policy Advocates. (n.d.). Everybody eats! Breakfast for learning. Retrieved May 16, 2003, from http://www.cfpa.net/caltaskforce.htm

61. NIH, National Institute on Drug Abuse. (2003, January). Cigarettes and other nicotine products [fact sheet]. Retrieved May 16, 2003, available at http://www.nida.nih.gov/Infofax/tobacco.html

62. NIH, National Institute on Drug Abuse. (2002, September). Criteria for substance dependency diagnosis: How can we tell if someone is abusing or addicted to drugs? Retrieved May 16, 2003, from http://www.drugabuse.gov/Drugpages/DSR.html

63. Monitoring the future. (2003). 2002 Data from in-school surveys of 8th, 10th and 12th grade students [data tables]. Retrieved December 7, 2002, from http://www.monitoringthefuture.org/data/02data.html#2002data-drugs

64. Leadership to keep children alcohol free. (n.d.). Kids and alcohol. Retrieved May 16, 2003, available from http://www.alcoholfreechildren.org/gs/index.htm

65. Grant, B.F., & Dawson, D.A. (1997). Age of onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: Results from the national longitudinal alcohol epidemiologic survey. Journal of Substance Abuse, 9, 103-110.

66. Division of Adolescent and School Health. (1999). Youth risk behavior surveillance-United States. Morbidity and Mortality Weekly Report. [Vol. 49, No. SS05, pp. 1-94]. Rockville, MD: CDC, National Center for Chronic Disease Prevention and Health Promotion

67. Kirby, D. (1997). No easy answers: Research findings on programs to reduce teen pregnancy. Washington, DC: The National Campaign to Prevent Teen Pregnancy

68. Grunbaum, J.A. et al. (2002). Youth risk behavior surveillance-United States, 2001. Morbidity and Mortality Weekly Report. [Vol. 51, No. SS04, pp. 1-64]. Washington, DC: U.S. Government Printing Office

69. Division of Adolescent and School Health. (1997). Youth risk behavior surveillance, national college health risk behavior survey, United States, 1995. Morbidity and Mortality Weekly Report. [Vol. 46, No. SS06, pp. 1-56]. Washington, DC: U.S. Government Printing Office

70. Novartis Foundation for Gerontology. (2003). Emotional health center. Retrieved on February 25, 2003, available from http://www.healthandage.com/Home/gm=20

71. CDC, National Center for Injury Prevention and Control. (2003). Suicide in the United States. Retrieved December 7, 2002, from http://www.cdc.gov/ncipc/factsheets/suifacts.htm

72. Suicide @ Rochford.org (2001, September). Information: Warnings. Retrieved February 25, 2003, from http://www.rochford.org/suicide/inform/warnings/

73. U.S. Census Bureau, United States Department of Commerce. (1997, September). Children with single parents: How they fare (census brief). Retrieved from http://www.census.gov/prod/3/97pubs/cb-9701.pdf

74. U.S. Census Bureau, United States Department of Commerce (n.d.). Household size, household type, and presence of own children 2000 [Data file]. Available from http://factfinder.census.gov/servlet/BasicFactsServlet

75. State of California Department of Child Support Services (2002). Child support handbook: Understanding the child support system and legal process. Retrieved January 11,2003, available from http://www.chhs.ca.gov/

76. Office of the District Attorney, Santa Clara County (2001). The family support division progress report. Santa Clara County: California.

77. Office of the District Attorney, Santa Clara County (2000). The family support division progress report. Santa Clara County: California.

78. Santa Clara County Social Services Agency (2002). Quarterly statistical data of public assistance families in the county of Santa Clara. Santa Clara County: California.

79. Santa Clara County Social Services Agency. (2003). The need for foster and adoptive resource families. Retrieved May 16, 2003, available from http://www.sccgov.org/channel/0,4770,chid%253D51061%2526sid%253D11754,00.html

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Endnotes continued

80. California Department of Social Services (2003). The federal child and family services review project. Retrieved April 16, 2003, from http://www.dss.cahwnet.gov/cfsr/Informatio_1312.htm

81. Santa Clara County Social Services Agency,Department of Family and Children's Services. (2003). California Children. Retrieved February 6, 2003 from http://www.adoption.org/Santa Clara/

82. University of California, Berkeley, The Center for Social Services Research. (2002). Child welfare statistics by county [Data file]. Retrieved April 16, 2003, available from the Child Welfare Research Center at http://cssr.berkeley.edu/CWSCMSreports/countyformresponse.asp?county=43)

83. University of California, Berkeley, The Center for Social Services Research. (2002). Child welfare supervised foster care highlights from CWS/CMS. Retrieved April 16, 2003, from http://cssr.berkeley.edu/CWSCMSreports/Highlights/data/CWFC_Q3_02_V1.pdf

84. Grissmer, D.W., Kirby, S.N., Berends, M., & Williamson, S. (1994). Student achievement and the changing American family (RAND corporation). Abstract retrieved May 16, 2003, from http://www.rand.org/publications/randreview/issues/RRR.winter94.5.education/The_Family.html

85. Centers for Disease Control and Prevention. (2003, February). Health topic: Violence/Suicide. Retrieved May 16, 2003, available from http://www.cdc.gov/health/violence.htm

86. County of Santa Clara, Law and Justice (2003). Domestic Violence. Retrieved February 6, 2003, from http://www.sccgov.org/channel/0,4770,chid%3D58779,00.html

87. State of California Department of Justice (2002). Domestic violence-related calls for assistance, 2000 (table). Retrieved September 3, 2002 from http://justice.hdcdojnet.state.ca.us/cjsc_stats/prof00/43/14.pdf

88. Domestic Violence Council of Santa Clara County (2002). Domestic violence in Santa Clara county annual report, 2001. Retrieved May 16, 2003, available from http://www.growing.com/nonviolent/index.htm

89. Santa Clara County Social Services Agency (2003). What is child abuse. Retrieved May 16, 2003, from http://www.sccgov.org/channel/0,4770,chid%253D16952%2526sid%253D13397,00.html

90. Santa Clara County Social Services Agency, Department of Family and Children's Services (2002). Abuse and neglect complaints, and disposition up to fiscal year 2000-2001. Santa Clara County: California

91. Santa Clara County Social Services Agency. (2003). The extent of the problem. Retrieved May 6, 2003 from http://www.sccgov.org/channel/0,4770,chid%253D16954%2526sid%253D13397,00.html

92. Head Start Santa Clara County Office of Education (n.d.). Santa Clara County Head Start Transition Project: San Jose, California. Retrieved February 6, 2003, from http://www.ed.gov/pubs/Compre/santa.html.

93. California Resource and Referral Network. (n.d). California child care portfolio, 2001. Retrieved May 15, 2003, from www.rrnetwork.org, http://www.rrnetwork.org/uploads/1012952297.pdf

94. Children NOW. (2003). California county data book 1999: How our youngest children are fairing. Retrieved May 16, 2003, from http://www.childrennow.org/california/rc99/databook-99.pdf

95. US Charter Schools. (n.d.). Overview of charter schools. Retrieved April 30, 2003, from http://www.uscharterschools.org/pub/uscs_docs/gi/oversview.htm#benefits

96. Santa Clara County Office of Education. (n.d.). Alternative school department handbook. Retrieved May 15, 2003, from http://www.sccoe.k12.ca.us/resourcesfamilies/related_resources/asdhandbook/default.asp

97. Santa Clara County Office of Education, Alternative School Department. Alternative school accountability report card, 2001-2002. Santa Clara County: California.

98. Project Cornerstone. (1999). School Survey Results. Retrieved August 8, 2002, from http://www.thecornerstoneproject.com/school_survey.htm

99. Project Cornerstone (1999). Percent of youth in Santa Clara County reporting each asset with comparison to percent in specific school/district, national aggregate and Seattle. Santa Clara

100. California Department of Education. (2002, November 29). 2002 STAR reports. Retrieved May 16, 2003, available from http://star.cde.ca.gov/star2002

101. California Department of Education. (2003, March 03). Calculating the academic performance index, 2001. Retrieved May 16, 2003, available from http://www.cde.ca.gov/psaa/api/

102. Santa Clara County Office of Education. (2002, January 16). Santa Clara county school districts 2001 base academic index report (press release). Retrieved May 16, 2003, from http://www.sccoe.org/newsandfacts/newsreleases/newsarchive/2002/2002api.asp

103. United States Department of Education. (n.d.). Preparing your child for college: A resource book for parents, 2000. Retrieved May 16, 2003, from http://www.ed.gov/pubs/Prepare/

104. The College Board. (2003). The new SAT. Retrieved May 16, 2003, from http://www.collegeboard.com/about/newsat/newsat.html

105. ACT. (2003). The test. Retrieved May 16, 2003, from http://www.act.org

106. California Department of Education, Office of Policy and Evaluation. (n.d.). 2000-01 SAT (Re-centered) and ACT report county report [data file]. Retrieved January 16, 2003, available from DataQuest, http://data1.cde.ca.gov/dataquest/

107. California Department of Education, Education Planning and Information Center. (2003, May). SAT-1 Report Santa Clara 2001-2002 [data file]. Retrieved February 10, 2003, available from DataQuest, http://data1.cde.ca.gov/dataquest/

108. California Department of Education, Educational Demographics Unit (2002). Expulsion information for Santa Clara county, 2001 [Data file]. Available from DataQuest, http://data1.cde.ca.gov/dataquest/

109. California Department of Education. (2002, October 22). School attendance review boards. Retrieved May 16, 2003, from http://www.cde.ca.gov/spbranch/safety/resourceguides/sarb.asp

110. County of Santa Clara Office of the District Attorney. (n.d.). Truancy laws (brochure). Retrieved April 27, 2003, from http://www.sccgov.org/scc/assets/docs/126649Truancylaw.pdf).

111. Community Crime Prevention Associates. (2000). Santa Clara County 601 status offender report of findings. Santa Clara: California

112. California Department of Education. (2002, September 30). State policy and guidelines. Retrieved May 16, 2003, from http://www.cde.ca.gov/spbranch/safety/policies/policies.asp

113. California Department of Education, Educational Demographics Unit (2002). Expulsion information for Santa Clara county, 2001 [Data file]. Available from DataQuest, http://data1.cde.ca.gov/dataquest/

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Endnotes continued

114. California Department of Education. (n.d.). Glossary. http://data1.cde.ca.gov/dataquest/gls_drpcriteria.htm

115. Kids in Common. (2002, December). Santa Clara county children's report fall 2002. Santa Clara County: California

116. California Department of Education, Educational Demographics Unit (2002). Santa Clara County dropout rates, 2001. [Data file]. Available from DataQuest, http://data1.cde.ca.gov/dataquest/

117. California Department of Education, Educational Demographics Unit (2002). Classroom teacher credential and experience report, 2001. [Data file]. Available from DataQuest, http://data1.cde.ca.gov/dataquest/

118. American Federation of Teachers, Department of Research (2002). Survey and analysis of teacher salary trends, 2001. Retrieved March 3, 2003, from http://www.aft.org/research/survey01/index.html

119. California Department of Education. (1999, July). 1999-2000 Guide K-3 class size reduction program. Retrieved May 16, 2003, from http://www.cde.ca.gov/classsize/sy9900/guide.htm#intro

120. California Department of Education, Educational Demographics Unit (2002). Pupil teacher ratio, 2000-2002. [Data file]. Available from DataQuest http://data1.cde.ca.gov/dataquest/

121. EdSource. (2001, September). How California ranks: A comparison of education expenditures (summary). Retrieved from http://www.edsource.org/pub_abs_ranks01.cfm

122. U.S. Department of Education, National Center for Education Statistics (2002, May 16). Revenues and expenditures for public elementary and secondary education: School year 1999–2000 (section). Retrieved May 5, 2003, from http://www.policyalmanac.org/education/archive/doe_education_spending.shtml

123. California Department of Education, School Fiscal Division. (n.d.). K-12 Education financial data. Retrieved May 16, 2003, available from http://www.cde.ca.gov/fiscal/financial/k12financialdata.htm

124. Santa Clara County Office of Education. (2002, January 16). Facts about Santa Clara county schools. Retrieved January 9, 2003, from http://www.sccoe.org/newsandfacts/sccpublicschools/default.asp

125. Sacramento County Children's Coalition. (n.d.). Sacramento county children's report card, September 2000 (per pupil expenditure). Retrieved May 1, 2003, from http://www.saccounty.net/children/report-card/education/per-pupil-exp.html

126. California Department of Education (2003, May). Safe school and violence prevention. California safe school assessment results. Retrieved May 16, 2003, available from http://www.cde.ca.gov/spbranch/safety/

127. Santa Clara County Office of Education. (2002, February 28). Santa Clara County 2000-2001 safe schools assessment results [press release]. Retreived May 16, 2003, from http://www.sccoe.org/newsandfacts/newsreleases/newsarchive/2002/safeschool02.asp

128. California Department of Education (2002, April). Safe schools and violence prevention: Zero tolerance. Retrieved April 28, 2003, from http://www.cde.ca.gov/spbranch/safety/policies/zerotolerance.asp

129. Neighborhoods, USA. Neighborhood resource section (n.d.). Retrieved May 15, 2003, from http://www.nusa.org/safety.htm

130. American Psychological Association (1998). Hate crimes today: An age-old foe in modern dress. Retrieved April 23, 2003, from http://www.apa.org/pubinfo/hate/

131. Hate Crime Network (n.d.). Retrieved April 2, 2003, from http://hate-crime.website-works.com/hate_incidents.htm

132. State of California Department of Justice, Criminal Justice Statistics Center. (2001). Hate crime in California, 2002 [publication]. Retrieved May 20, 2003, available from http://caag.state.ca.us/cjsc/pubs.htm

133. Santa Clara County Network for a Hate-Free Community (2003). Fast facts: hate incidents/crimes reported. Retrieved January 27, 2003, from http://www.hateistheenemy.com/channel/0,4770,chid%253D63729%2526sid%253D13980,00.html

134. Federal Bureau of Investigation (n.d.). Hate crime statistics, 2001. Retrieved May 8, 2003, available from http://www.fbi.gov/ucr/ucr.htm

135. Superior Court of California, County of Santa Clara (n.d.). Juvenile delinquency court description. Retrieved April 24, 2003, available from http://www.scselfservice.org/juvdel/default.htm

136. State of California Department of Justice. (2001). Juvenile felony arrests by gender, offense and offense rate [table]. Retrieved September 3, 2002, from http://justice.hdcdojnet.state.ca.us/cjsc_stats/prof01/43/3C.htm

137. State of California Department of Justice. (2001). Crime statistics. Retrieved September 3, 2003, available from http://caag.state.ca.us/cjsc/datatabs.htm

138. State of California Department of Justice. (2001). Total misdemeanor arrests by gender, offense and arrest rate [table]. Retrieved March 4, 2003, from http://justice.doj.ca.gov/cjsc_stats/prof01/43/4A.htm

139. Santa Clara County Probation Department (2003). Juvenile Detention Division. Retrieved September 3, 2002, from http://www.sccgov.org/channel/0,4770,chid%253D91556%2526sid%253D11436,00.html

140. Santa Clara County Probation Department (2003). Retrieved on May 15, 2003, from http://www.sccgov.org/content/0,4745,ccid%253D36467,00.html

141. Santa Clara County Probation Department (2003). Retrieved on May 15, 2003, from http://www.sccgov.org/content/0,4745,ccid%253D36467,00.html

142. Santa Clara County youth on probation: 2000-2002 [enterprise data warehouse data file]. Santa Clara County, CA: Santa Clara County Probation Department.

CHKS Comparisons Report Matrix

California Healthy Kids Survey Report Matrix

The California Healthy Kids Survey Report Matrix is a summary table that presents comparable results with similar data elements and questions of the Santa Clara County California Healthy Kids Survey (CHKS) 2002 with the following survey reports: Santa Clara County Youth Behavioral Risk Factor Survey 1997, California CHKS 2001, and the National Youth Risk Behavior Survey (YRBS) 2001. Only comparable and common questions are presented in the table and all analysis are based on the overall sample unless specified. Any comparisons should be made cautiously as the percentages are not presented along with their confidence intervals to allow for sound and statistical conclusions about the trend. We plan to present this data in our next publication when data is available for 3 years for more meaningful trend analyses.

California Healthy Kids Survey (CHKS) Comparison Report Matrix

Behavior	Santa Clara County 1997 (YRBS)		Santa Clara County 2002 (CHKS)				National 2001 (YRBS)
	Middle School	High School	Middle School				High School
Demographics							
Gender							
Male	46.0	44.0	47.7	48.0	45.0	45.8	48.7
Female	54.0	55.3	52.3	52.0	55.0	54.2	51.3
Grade Level							
7th	42.8	NA	34.4	NA	36.6	NA	NA
9th	NA	29.9	NA	32.6	NA	30.2	29.7
11th	NA	27.3	NA	33.1	NA	33.2	23.1
Race/Ethnicity							
White	26.8	35.6	34.7	35.0	26.4	34.6	67.5
Hispanic	34.6	22.5	31.9	29.5	30.4	30.4	10.3
Black	4.3	5.3	3.9	3.8	7.3	5.5	13.0
Asian	32.6	35.7	28.4	29.5	9.7	12.1	3.4
American Indian	1.8	1.0	0.8	0.8	2.3	1.6	0.7
Personal Safety							
Rarely or never wore a bicycle helmet, when riding a bicycle (among riders)	45.1	64.8	35.2	53.0	NA	NA	84.7*
Rarely or never wore a seat belt when riding in a car driven by someone else	6.6	5.3	11.1	10.6	NA	NA	14.1
Ever driven a car when drinking alcohol, or been in a car driven by a friend when he or she had been drinking	26.8	NA	38.4	24.5	41.1	53.3	NA
Perception of Safety at School	NA	NA	87.8	88.9	81.1	84.0	NA
Perception of Safety in neighborhood	NA	NA	91.1	92.2	87.0	87.5	NA
Harassment (in the last 12 months)							
Harassed or bullied for race, ethnicity, or national origin on school property	NA	NA	13.2	15.0	13.0	14.0	NA
Harassed or bullied for religion on school property	NA	NA	8.1	8.2	7.0	7.5	NA
Harassed or bullied for gender on school property	NA	NA	10.2	9.4	8.0	8.5	NA
Harassed or bullied because gay or lesbian or someone thought you were on school property	NA	NA	8.5	6.7	9.0	5.5	NA
Harassed or bullied for a physical or mental disability on school property	NA	NA	4.3	4.1	4.0	4.5	NA
Harassed or bullied for any other reason on school property	NA	NA	24.4	20.8	21.0	16.5	NA

Behavior	Santa Clara County 1997 (YRBS)		Santa Clara County 2002 (CHKS)				National 2001 (YRBS)
	Middle School	High School	Middle School				High School
Violence							
During the past 12 months, have you had your property stolen or deliberately damaged, such as your car, clothing or books on school property?	NA	34.6	13.1	16.1	27.0	27.5	NA
During the past 12 months, have you damaged school property on purpose?	NA	NA	13.1	16.1	12.0	16.0	NA
During the past 30 days, did you carry a weapon such as a knife or club?	NA	16.5	5.9	7.3	NA	NA	17.4
During the past 30 days, did you carry a gun?	NA	4.8	2.3	2.7	NA	NA	5.7
During the past 30 days, did you carry a gun on school property?	NA	NA	1.4	1.6	1.0	2.0	NA
During the past 30 days, did you carry any other weapon on school property?	NA	NA	4.9	6.2	3.0	6.5	NA
During the past 30 days, did you not go to school because you felt you would be unsafe at school or on your way to or from school?	NA	4.9	6.6	10.0	NA	NA	6.6
During the past 12 months, have you been pushed, shoved, slapped, hit, or kicked by someone who wasn't just kidding around on school property?	NA	NA	42.7	27.0	45.0	25.0	NA
During the past 12 months, has someone threatened or injured you with a weapon such as a gun, knife or club on school property?	NA	7.4	7.8	7.5	9.4	7.9	8.9
During the past 12 months, were you in a physical fight?	NA	31.4	28.6	25.7	NA	NA	33.2
During the past 12 months, were you in a physical fight in which you were injured and had to be treated by a doctor or nurse?	NA	3.9	3.7	3.9	NA	NA	4.0
During the past 12 months, were you in a physical fight on school property?	NA	14.4	26.8	20.3	27.1	21.4	12.5
During the past 12 months, have you carried a gun on school property?	NA	NA	3.0	3.4	2.0	2.9	NA
During the past 12 months, have you carried any other weapon on school property?	NA	NA	8.8	10.7	5.2	8.7	NA
During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose? (among those who are in a relationship)	NA	NA	7.7	9.1	6.7	9.5	9.5
Have you ever been forced to have sexual intercourse when you did not want to?	NA	NA	4.0	6.4	NA	NA	7.7
Have you ever belonged to a gang?	NA	NA	8.4	9.0	9.0	10.5	NA
Suicide							
During the past 12 months, did you ever feel so sad or hopeless almost everyday for two weeks or more in a row that you stopped doing some usual activities?	NA	NA	24.4	31.3	25.0	32.5	28.3
During the past 12 months, did you ever seriously consider attempting suicide?	NA	22.3	22.0	19.9	NA	NA	19.0
During the past 12 months, did you make a plan about how you would kill yourself?	NA	18.0	10.1	14.7	NA	NA	14.8
Have you ever tried to kill yourself?	9.0	NA	7.3	NA	NA	NA	NA
During the past 12 months, did you actually attempt suicide?	NA	9.6	NA	8.7	NA	NA	8.8
If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor?	NA	17.8	NA	24.9	NA	NA	30.7

Behavior	Santa Clara County 1997 (YRBS)		Santa Clara County 2002 (CHKS)				National 2001 (YRBS)
	Middle School	High School	Middle School				High School
Tobacco Use							
Have you ever tried cigarette smoking, even one or two puffs?	33.1	56.8	16.6	38.1	18.8	48.3	63.9
During your life, have you ever used or tried a whole cigarette?	NA	NA	6.0	24.9	6.9	28.2	NA
How old were you when you smoked a whole cigarette for the first time? (Smoked a cigarette before age 13)	22.1	19.3	NA	13.7	NA	NA	22.0
Prevalence of current smoking (smoked in last 30 days)	10.7	24.2	3.0	11.2	4.3	15.0	28.5
Prevalence of frequent smoking (>20 cigarettes in one month)	1.2	7.8	0.4	4.0	0.3	3.6	13.9
During the past 30 days, on the days that you smoked, how many cigarettes did you smoke per day? (more than 10 cigarettes)	2.9	5.7	6.0	6.2	NA	NA	4.2
During the past 30 days, how did you usually get your own cigarettes? (Store or gas station)	5.1	14.8	9.8	18.2	NA	NA	23.2
When you bought cigarettes in a store during the past 30 days, were you ever asked to show proof of age? (Not asked to show proof)	82.6	69.9	82.7	NA	NA	NA	46.9
During the past 30 days, did you smoke cigarettes on school property?	NA	10.4	1.8	5.2	1.8	5.2	9.9
Have you ever smoked cigarettes regularly, that is, at least one cigarette every day for 30 days?	1.0	4.9	2.0	9.8	NA	3.5	20.0
If you now smoke cigarettes, would you like to quit smoking? (among those who smoke)	NA	NA	44.1	50.3	NA	NA	NA
Have you ever tried to quit smoking cigarettes? (among those who smoke)	NA	45.6	47.1	56.3	NA	44.1	57.4**
If you used tobacco during the past 12 months, did you go to a special group or class at school to get help quit using? (among those who smoke)	NA	NA	93.3	92.7	NA	NA	NA
How likely do you think it is that you will smoke one or more cigarettes in the next year? (Surely/probably)	NA	NA	4.0	11.6	NA	NA	NA
During your life, have you ever used or tried smokeless tobacco?	3.8	NA	3.1	6.9	2.4	6.7	NA
During the past 30 days, did you use smokeless tobacco? (current use)	NA	2.5	1.3	2.3	0.8	2.1	8.2
About how many adults you know smoke cigarettes once a month or more?	NA	NA	21.3	28.6	NA	NA	NA
During the past 30 days, did you smoke cigars, cigarillos, or little cigars?	NA	NA	5.8	14.0	NA	NA	15.2
Do you think it is harmful to use cigarettes occasionally?	NA	NA	84.5	78.6	79.0	84.0	NA
Do you think it is harmful to use cigarettes frequently?	NA	NA	94.2	95.2	95.4	95.3	NA
Is it difficult for students in your grade to get cigarettes if they really want them?	NA	NA	40.5	13.2	35.2	10.3	NA
Smoking makes kids look grown up	NA	NA	13.8	13.0	NA	NA	NA
Smoking makes your teeth yellow	NA	NA	91.5	94.3	NA	NA	NA
Smoking is cool	NA	NA	8.3	7.6	NA	NA	NA
Smoking makes you smell bad	NA	NA	87.1	88.6	NA	NA	NA
Smoking helps you make friends	NA	NA	10.6	13.7	NA	NA	NA
Smoking is bad for your health	NA	NA	87.0	90.8	NA	NA	NA
Smoking helps you relax	NA	NA	16.5	37.0	NA	NA	NA
Smoking helps you control your weight	NA	NA	8.3	7.6	NA	NA	NA

Behavior	Santa Clara County 1997 (YRBS)		Santa Clara County 2002 (CHKS)				National 2001 (YRBS)
	Middle School	High School	Middle School				High School
During your life, have you ever used or tried one full drink of alcohol?	51.5	65.5	17.1	50.1	21.4	56.8	NA
How old were you when you had your first drink of alcohol other than a few sips? (Drank Alcohol before age 13)	48.1	27.8	15.5	21.3	NA	NA	29.0
During the past 30 days, did you have at least one drink of alcohol? (Current Use)	NA	39.5	10.6	28.2	10.4	35.0	47.1
During the past 30 days, did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?	NA	22.9	3.0	14.5	2.9	19.8	4.9
During the past 30 days, did you have at least one drink of alcohol on school property?	NA	7.1	2.6	5.3	3.5	8.5	4.9
During your life, have you been very drunk or sick after drinking alcohol?	NA	NA	7.5	31.1	8.1	32.6	NA
Do you think it is harmful to use alcohol? (No harm)	NA	NA	7.8	8.8	4.3	6.2	NA
Is it difficult for students in your grade to get alcohol if they really want it? (No difficulty)	NA	NA	30.9	70.8	34.4	75.1	NA
Marijuana							
During your life, have you ever used or tried marijuana?	14.1	38.8	7.0	30.0	8.5	34.1	42.4
How old were you when you tried marijuana for the first time? (Tried Marijuana before age 13)	11.5	11.5	4.9	8.9	NA	NA	10.2
During the past 30 days, did you use marijuana? (Current Use)	NA	20.9	3.9	15.9	4.0	18.2	23.9
During the past 30 days, did you use marijuana on school property?	NA	7.8	1.6	5.3	2.8	7.4	5.4
Do you think it is harmful to use marijuana? (No/minimal harm)	NA	NA	5.2	12.0	5.0	9.5	NA
Is it difficult for students in your grade to get marijuana if they really want it? (No difficulty)	NA	NA	16.4	60.8	19.9	69.8	NA
Other Drugs							
During your life, have you ever tried or used any form of cocaine, including powder, crack or freebase?	3.6	9.5	2.6	6.8	2.1	6.6	9.4
During the past 30 days, did you use any form of cocaine, including powder, crack or freebase? (Current Use)	NA	3.7	NA	2.4	NA	0.1	4.2
During your life, have you ever used or tried inhalants?	15.6	14.7	10.3	11.8	6.3	11.0	14.7
During the past 30 days, did you use inhalants? (Current Use)	NA	NA	4.2	3.3	2.5	3.8	4.7
During your life, have you ever used or tried methamphetamine or any amphetamines?	NA	NA	NA	7.9	1.8	6.2	9.8
During the past 30 days, did you use methamphetamine? (Current Use)	NA	NA	NA	2.8	NA	3.3	NA
During your life, have you ever used or tried LSD or other psychedelics?	NA	NA	NA	8.2	2.0	7.1	13.3
During your life, have you ever used or tried ecstasy?	NA	NA	NA	10.0	2.1	8.2	11.1
During your life, have you ever used or tried heroin?	NA	NA	NA	2.9	NA	2.2	3.1
During your life, have you ever used steroid pills or shots without a doctor's orders?	2.5	2.7	2.1	NA	NA	NA	5.0
During your life, have you used a needle to inject any illegal drug into your body?	1.3	1.6	1.4	NA	NA	NA	2.3
During the past 12 months, has anyone offered, sold, or given you an illegal drug on school property?	NA	37.7	11.6	36.2	9.1	35.7	28.5
During your life, have you been "high" from using drugs?	NA	NA	6.6	28.2	7.2	32.0	NA
During your life, have you been drunk or "high" on drugs on school property?	NA	NA	3.4	16.1	3.3	20.2	NA
During your life, have you ever used or tried any other illegal drug?	NA	NA	3.9	8.9	NA	10.3	NA

Behavior	Santa Clara County 1997 (YRBS)		Santa Clara County 2002 (CHKS)				National 2001 (YRBS)
	Middle School	High School	Middle School				High School
Sexual Behavior							
Have you ever had sexual intercourse?	9.6	31.1	9.9	24.8	NA	NA	45.6
How old were you when you had sexual intercourse for the first time? (Sexual intercourse before age 13)	6.7	3.8	7.9	3.9	NA	NA	6.6
During the past 3 months, with how many people did you have sexual intercourse? (2 or more)	NA	6.1	NA	5.5	NA	NA	9.0
Did you drink alcohol or use drugs before you had sexual intercourse the last time? (among those who are currently sexually active)	NA	24.6	NA	23.9	NA	NA	25.0
The last time you had sexual intercourse, did you or your partner use a condom? (among those who are currently sexually active)	NA	57.2	51.4	62.9	NA	NA	61.0
Method of preventing pregnancy			NA				
Condom	59.1	50.5		54.8	NA	NA	51.3
Pills		11.0		13.0	NA	NA	16.0
No Method		17.1		15.6	NA	NA	14.0
Withdrawl		11.2		7.3	NA	NA	0.1
Depo Provera		NA		3.9	NA	NA	0.0
Not Sure		2.9		3.7	NA	NA	0.0
Other		4.8		1.6	NA	NA	0.0
Have you been pregnant or gotten someone pregnant?	NA	3.8	NA	3.4	NA	NA	5.8
Is it likely that you will choose to have sexual intercourse one or more times in the next year?	NA	NA	7.2	21.1	NA	NA	NA
Body Weight							
How do you describe your weight? (Overweight)	26.7	28.7	30.5	32.9	NA	NA	29.3
Which of the following are you trying to do about your weight? (Currently attempting weight loss)	39.9	40.0	47.6	47.7	NA	NA	46.0
During the past 30 days, did you exercise to lost weight or to keep from gaining weight?	NA	52.7	66.2	68.1	NA	NA	59.9
During the past 30 days did you eat less food, fewer calories or foods low in fat to lose weight or to keep from gaining weight?	NA	27.1	39.6	45.0	NA	NA	43.8
During the past 30 days, did you take any diet pills, powders, or liquids without a doctor's advice to lose or to keep from gaining weight?	NA	3.8	5.2	7.2	NA	NA	9.2
During the past 30 days, did you vomit or take laxatives to lose weight or to keep from gaining weight?	NA	4.8	5.4	6.0	NA	NA	5.4
Nutrition							
Did you eat breakfast today?	NA	NA	66.8	58.6	62.0	52.5	NA
During the past 24 hours, did you eat french fries, potato chips, or other fried potatoes?	49.4	49.5	62.2	64.1	64.0	68.0	NA
During the past 24 hours, did you eat fruit	77.3	68.4	81.0	76.0	74.0	69.5	NA
During the past 24 hours, did you eat vegetables?	54.5	55.4	80.2	80.8	71.0	70.0	NA
During the past 24 hours, did you drink fruit juice?	71.9	70.9	73.3	74.4	74.0	70.5	NA
Ate five or more servings of fruits and vegetables in the past 24 hours***	42.8	33.7	53.8	49.6	40.0	33.0	NA

Behavior	Santa Clara County 1997 (YRBS)		Santa Clara County 2002 (CHKS)				National 2001 (YRBS)
	Middle School	High School	Middle School				High School
Physical Activity							
During the past 7 days, did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard.	95.0	84.3	94.3	88.3	72.0	65.5	84.2
During the past 7 days, did you participate in physical activity for at least 30 minutes that **did not** make you sweat or breathe hard.	NA	NA	79.6	80.8	47.0	50.0	70.2
During the past 7 days, did you do exercises to strengthen or tone your muscles such as push-ups, . . . ?	NA	67.3	NA	80.9	NA	80.0	75.2
On an average school day, how many hours of TV do you watch? (2 or more hours)	NA	NA	50.5	54.2	NA	NA	61.7
Preventive Care							
During the past 12 months, did you have a regular check up with a doctor when you were not sick or injured?	NA	NA	56.9	57.4	NA	NA	55.9
Oral Health							
During the past 12 months, did you visit a dentist for an examination, teeth cleaning, or dental work?	NA	NA	79.9	80.5	NA	NA	68.7
Asthma							
Has a doctor ever told you or your parent/guardian that you have asthma?	NA	NA	31.6	27.1	NA	NA	NA
In the past 12 months, have you been to a doctor or hospital for wheezing or trouble breathing?	NA	NA	9.7	9.3	NA	NA	NA
AIDS Education							
Have you ever been taught about AIDS or HIV infection in school?	73.1	93.3	63.7	NA	NA	NA	89.0
School Success							
During the past 12 months, how would you describe the grades you mostly received in school?	NA	NA	X	X	NA	NA	
Mostly A's				24.5	22.0	15.0	26.6
A's & B's				32.8	36.0	29.5	NC
Mostly B's				9.9	8.0	11.0	39.3
B's & C's				17.0	21.0	23.5	NC
Mostly C's				5.6	5.0	8.0	23.7
C's & D's				6.7	6.0	9.0	NC
Mostly D's & F's				3.4	2.0	4.0	6.2

* Past 12 mo

**Current smokers trying to quit in the past 12 mo

***Students who reported having eaten a particular type of food zero, one, or two times were assigned a frequency of 0, 1.0, or 2.0, respectively. Students who reported having eaten a particular food >=3 time were assigned a frequency of 3.0. The total number of servings per day was calculated based fruit juice, fruits, and vegetables.